



“Treat me like a human being, like someone who matters”

*Findings of the Stella Project Mental Health Initiative Survivor
Consultation*

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Introduction

This report presents the findings of a two-month consultation with survivors of domestic and sexual violence who have also experienced problematic substance use and/or mental ill-health, which was conducted as part of the Stella Project Mental Health Initiative. The Stella Project Mental Health Initiative (SPMHI) is a three-year project, funded by the Department of Health, that aims to improve responses to victims and perpetrators of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health. All three issues are core areas of work, frequently intertwined, for health and social care professionals, with substance use becoming further incorporated into the health paradigm with the transition of the National Treatment Agency into Public Health England.

The consultation was undertaken in order to inform the development of a toolkit and e-learning package, that will be developed in the final year of the project. The consultation comprised:

- A written survey completed by 31 survivors who attended a Women's Health Day convened by Nottingham Crime and Drugs Partnership
- Individual interviews with five survivors in Nottingham and three survivors in Hounslow
- Focus groups with 60 survivors in Bristol and Nottingham

This consultation has provided a wealth of information about how services currently address the overlapping issues of domestic and sexual violence, problematic substance use and mental ill-health and what service users desire from service providers.

Key themes

1) The importance of humanity

Professionals tend to focus on establishing survivors' needs and identifying ways to meet a wide range of needs. When asked what advice they would give professionals about how to respond to survivors of domestic and sexual violence who also have experiences of problematic substance use and/or mental ill-health, the majority of survivors consulted within the SPMHI noted first and foremost the need to be valued and treated like a human being:

“Asking for help is the most difficult thing you can ever do. And when you do that, you just want someone to say “look, it’s not your fault, and we’re going to get you some help, and you are not this worthless human being, you do deserve to live, you deserve to be a mother, you deserve to be happy, you don’t deserve this man smacking you round the face every time he has a drink, you know what I mean? That’s the first thing you need, then practical help. But what you really need is for someone to treat you like you’re worth something, you’re not just something out of the gutter.” (Nottingham interviewee)

“Try to be supportive and understanding” (Nottingham survey respondent)

“[Be] more approachable and not judgmental” (Nottingham survey respondent)

“Go gently – act with compassion” (Nottingham survey respondent)

Some survivors also highlighted the importance of small acts of respect and kindness are very important, for example workers calling if they are late for an appointment, being offered a cup of tea, and for one survivor, simply *“a friendly face and a hug can mean a lot”* (Nottingham, survey respondent). Similarly, a significant number of women referred to workers who are good because they listen, are not judgmental, have patience and do not force the survivors to take steps they were not ready for, are focused on the client and will *“keep going at it until [a problem] is sorted”* (Bristol focus group participant).

Survivors of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health tend to experience more stigma and negative responses from professionals than survivors who do not have these experiences. Survivors in one focus group in Bristol described:

being told to by a GP receptionist to get the bus to hospital when the survivor collapsed in the waiting room with alcohol poisoning
being told to *“stop crying”* by a mental health social worker whilst in hospital after attempting suicide
being told that *“if you are able to stand on a street corner, you can collect your [methadone] script”* when a woman who was involved in prostitution who was suffering from post-traumatic stress disorder tried to discuss potential difficulties in getting to her GP with her drugs worker.

The need to be non-judgmental and treat survivors like humans is particularly important as their self-worth is exceedingly low:

“You don’t want to have to tell someone that you’re an alcoholic, or a drug addict, or that your husband beats you up. Because it makes you feel crap like you’re worthless.” (Nottingham interviewee)

“The basic essence of it is that you are worth treating. By the time I got to that point it was like I can’t live with drink, I can’t live without drink, I’ve completely screwed up my whole life, my children’s life, I’m a horrible mother, nobody loves me, every one I go out with wants to beat the shit out of me, so where does that leave me? I’m nothing. And that’s how I felt.” (Nottingham interviewee)

2) Consistent and trusting relationships

Survivors in each area commented on the ways in which models of service provision and frequent changes in staffing disrupted their care as they did not feel they could build a relationship with professionals who might be able to assist them.

“You’ve got walk-in centres, I don’t want to go to a walk-in centre, I want to see someone who understand what’s happening” (Bristol focus group participant)

“You can’t ring and make an appointment; you’re given whatever doctor is on duty – never get the same doctor twice” (Bristol focus group participant)

“Different doctors change and up your prescriptions. I felt like a guinea pig. I took myself of the medication because I couldn’t trust the doctors” (Bristol focus group participant)

“Especially with mental health you need to be able to get to know your doctor” (Bristol focus group participant)

“I don’t like change. I want a doctor that knows my name and my story” (Hounslow interviewee)

“Sometimes you...disclose what you want to disclose in the room but you’re putting your trust in them...you wouldn’t know nothing about my kids...you don’t know my husband, my background but there’s a lot and still haven’t disclosed that part of it” (Nottingham interviewee).

For more than one survivor, the trusting relationship they had established with their GP was so important that it influenced their decision to move away from the area when fleeing domestic violence, i.e. she did not want to move as it would mean changing GPs.

When asked what helps build trust with a worker, the most common responses reflect the points raised in the previous section: being treated like a human being, being listened to and understood, not being overwhelmed with suggestions of things to do that the client wasn’t ready for, not being judged, not being treated as though you are crazy, their name and story being remembered so they don’t have to repeat their information and workers completing actions on their behalf.

3) The pivotal role of GPs

The GP was the most frequently mentioned service used by the survivors of domestic and sexual violence who participated in the SPMHI consultation. The second most mentioned service was the police. Survivors were clear that it “all depends on who you get” (Bristol focus group participant). Some survivors had very positive experiences:

“My GP was fantastic, spent lots of time with me and nothing was too much trouble for him” (Nottingham survey respondent)

“I had a GP that was very helpful. She was so strict, but she moved. She knew all about me, all the lies I would tell. But she moved, so that relationship goes. My previous doctor, she was real, she knew exactly. I would say I had drunk half a bottle, she would say “And how many more? Don’t come and tell me this rubbish because I know you.” (Nottingham interviewee)

“My GP is amazing: I’ve been with him for the past 10 years. He incorporates a counselling session into the appointment. He’s referred me on and is very reassuring” (Bristol focus group participant)

However, the majority of survivors noted that GPs simply do not have the time to provide the support needed: *“With all the budgets, the GPs don’t have the time, they don’t have the time to put into individual people. It’s a sad fact.”* (Nottingham interviewee) and as a result it can take a long time to get anything done.

Survivors suggested that GPs need more training around all three issues, as they are often the first service people turn to and a negative or unhelpful response could dissuade survivors from asking for help a second time: *“the first point of contact will stick in your head”* so *“[i]f you come across [a GP] who has no understanding of any of it, it makes you feel like a piece of shit, it puts you back to square one”* (Bristol focus group participants).

Survivors highlighted how GPs need to be more adept at spotting the signs of domestic violence or substance use, and encouraged GPs to *“not to be afraid to ask”* (Nottingham survey respondent) their patients about domestic violence and substance use as survivors do not always have the courage to disclose or need another person to take the lead:

“Often the first port of call is the doctors. And doctors shouldn’t believe you when you tell them – a lot of doctors will do that. In the past, I sort of wanted to some help but I’m not quite sure I wanted to stop. So I’ve said to the doctor that I’ve been drinking a bit too much, hoping really that he was going to say, right we’re going to stop this.” (Nottingham interviewee)

Furthermore, survivors noted the need for GPs to learn not to simply accept when patients say they are okay (when asked about domestic violence) or believe claims that patients *“only drink 2 glasses of wine a night”* as *“we, alcoholics, are liars”* (Nottingham interviewee). Similarly, GPs were also advised not to fully accept explanations given for injuries as they could be a result of domestic violence or substance use:

“Because the nature of drinking and taking drugs cause injuries...you go to the doctor because you sprain your ankle. I dropped a concrete slab on my foot when I was drunk. I just said I fell over. They need to be trained more.”
(Nottingham interviewee)

Finally, survivors described aspects of negative practice, with GPs being very dismissive, telling one woman to “pull herself together” (Nottingham interviewee), and quick to prescribe medication rather than enquire about patients’ lives and discuss alternative treatment options when medication appears ineffective:

“I was on anti-depressant for many years, but they don’t cure the problem. They are just handed out. I have done more in counselling in 6 or 7 weeks than anti-depressants have in years” (Nottingham interviewee)

“When I used to go to the doctor with pains, they used to just say it was anxiety or stress, not one of them referred me to a counsellor or anything like that, which is quite badly really...They seem better now. I’m making loads of progress. I had the assessment [for dual diagnosis] at my doctors but because I wasn’t very talkative, he sent me to another worker who referred me to CBT.”
(Nottingham interviewee)

Along similar lines, survivors in Bristol and Hounslow noted that GPs should be a conduit into other services but repeatedly had to refer themselves to counselling, or rely on key workers in other services to make referrals which they felt the GP could have made.

4) Unresponsive mental health services

Both practitioners and survivors who have been involved in the Stella Project Mental Health Initiative cite access to appropriate mental services as a key concern. Survivors in the Bristol focus groups, along with staff in domestic violence, sexual violence and drug and alcohol services are very clear that you have to present as extremely vulnerable, as posing a serious risk of harm to yourself or others before secondary mental health services will accept a referral. Practitioners in these services are working with women who present with high levels of psychological distress and other mental health problems that have typically resulted from trauma and abuse in childhood and adulthood, yet cannot access any support for their clients until it reaches crisis point.

At the other end of the scale, the Government has placed a great emphasis on rolling out Improving Access to Psychological Therapies (IAPT) services that only work with people who have mild to moderate depression and anxiety. These services are often inappropriate for survivors of domestic and sexual violence who are also affected by substance use or mental ill-health as staff are not trained to deal with such complex issues. As such many survivors are unable to access the support they need as their mental health problems are either too severe or not severe enough. This leaves support workers in other agencies, for example refuges, to manage these complex cases.

Workers and survivors both find the referral process difficult, having to access support through the GP and then navigate multiple referrals and assessments which may take place over months or even years:

“Then I went to dual diagnosis but they said my mental health weren’t severe enough so they sent me to Health and Mind. I worked with them but then I was pregnant so they had to refer me to perinatal. I went for like two appointments and I just weren’t with them. I called them one day and said ‘Look, I want to be discharged’, then I got a letter saying I weren’t engaging and I didn’t give a good enough reason to believe.” (Nottingham interviewee)

Feedback from survivors who have accessed mental health services is quite mixed. Experiences of secondary mental health services were more negative than other services, for example:

“I was in the middle of a relapse, feeling suicidal. I was seen by a social worker for 20 minutes. Her response was “when you stop using you’ll be better”. As far as she was concerned, I didn’t fit the criteria and I was sent back to the GP. I just kept using” (Bristol focus group participant)

“I find people can be a bit judgmental. It might be my perception, but...it’s like in the hospital, you choose it, you chose to take an overdose...but I was feeling crap. The nurses got a bit moody like she didn’t want to be with me” (Nottingham interviewee)

“Even when I got in touch with the crisis team, when I was telling them how I was feeling, it was like ‘stop being so negative’ and I didn’t really feel that supported” (Nottingham interviewee)

“I had to go through my GP to receive help through [the] mental health team. I went...in 2010 and they just gave me medication and said goodbye, like.” (Bristol focus group participant)

Each mental health team works differently, however, and some survivors have found the contact positive: *“[this team] have been more supportive and I’ve had a psychiatrist and I’ve had CPN contact and I’ve done CBT work and self-destructive therapy so, and anger management.” (Bristol focus group participant)*. However, overall, survivors with mental health problems have highlighted the value of peer-led support, support groups for self-harming and anxiety, day centres and organisations such as Mind, that provide a wide range of activities to keep people occupied.

5) Limited access to therapeutic support

Survivors fed back varying views on the value of therapeutic support, i.e. counselling and other psychological services, with many women indicating they had no need to talk to someone about their experiences of abuse. A smaller number of survivors did note the benefits and recognise that they cannot recover from abuse without therapeutic support:

“[I] find it helpful but sometimes I don’t know what to say...I haven’t spoken to them much about my experiences with my ex. It’s not something I need to talk about. I’ve talked about some things from childhood. It’s good that he’s there to listen not to judge.” (Nottingham interviewee)

“My last relapse was really bad. Something happened and the counseling has helped with that. I had one-to-one, I felt at ease with the counsellor, she’s a

woman, I was able to explain to what had happened, something I didn't think I needed to talk about but I had carried around for 25 years.” (Nottingham interviewee)

For those survivors who do wish to access counselling or another type of therapy, access is severely limited. As noted in the previous point, GPs now commonly refer depressed and anxious patients to their local IAPT service. These services are generally ill-equipped to deal with the complexity of problems that survivors of domestic and sexual violence may present with. A survivor from one of the Nottingham focus groups who suffers from periods of quite severe depression and problematic alcohol use described her IAPT worker meeting with her three times, handing her a self-help manual to manage depression and then closing the case. For this survivor, like many others, her experience of the IAPT service has put her off contacting her GP for further support as she believes this is all that is available. In another part of the country, a survivor attended an IAPT assessment and was advised to come back when she knew what she wanted as she was too confused at the assessment.

In training IAPT workers in one area of the country, it is also apparent that not all services screen (routinely or otherwise) for substance use, domestic violence or sexual violence. Furthermore, in some cases victims of domestic violence are excluded from IAPT services because they are at risk of harm – not that they pose too great a risk of harm to themselves or others, but that they are *at risk of harm from others*. Excluding individuals from a support service because they are being abused is unacceptable and unnecessary.

6) Lack of appropriate accommodation-based services

As highlighted in other research including the Stella Project refuge mapping report (available shortly), survivors of domestic violence who are affected by substance use and/or mental ill-health have very limited access to safe accommodation if they choose to leave an abusive partner.

Evidence from the SPMHI survivor consultation also highlighted how many refuges do support women with mental health and/or substance use problems, quite often because these additional needs are not disclosed at referral stage. Unfortunately, feedback suggests that refuge staff are frequently lacking in training and confidence to deal with these issues. In one case, for example:

“When I went down to say I felt like self-harming they didn't know what to say or what to do. I think they need a bit of training. I didn't want to self-harm at the time, I went down and said I don't want to self-harm, I don't know what to do. They could have given me numbers to call.” (details withheld¹)

When combined with the difficulties in accessing secondary mental health services, a lack of training for staff in how to support service users with mental health or substance use problems can increase the risk to survivors:

“I went from being supported to unsupported. Being in a harder situation. [Before the refuge], I was going to groups. I was self-harming, there was a

¹ The location of the survivors in this section have been withheld to ensure they cannot be identified.

group for self-harming and I had the crisis team coming out...so support there. There was a group where we got help and advice. Nothing happened [between the mental health teams in her hometown and where the refuge was located]. I took an overdose (in the refuge) and the crisis team got involved – that was the first I'd heard of them. (details withheld)

Similarly, refuge service users spoke of living with women who were over-medicating or under-medicating themselves and as a result became very lethargic and sometimes neglectful towards themselves and at other times could behave in a way that frightened other service users, including making threats with a knife. According to the service users consulted (one of whom used to be a mental health worker), the refuge staff did not know how to support service users with mental health problems and were unable to maintain clear boundaries. In two areas of the country, survivors also recounted routine incidents of substance use in refuge and other accommodation-based services. For survivors from two refuges, this was particularly detrimental as they were in recovery and being in an environment where other women were using was “*dangerous*” (details withheld). From the evidence provided, it is clear that refuges are accepting women with higher mental health and substance use problems but these issues do not appear to be managed effectively.

Survivors with both drug and alcohol and mental health problems also highlighted the need to keep busy as a way of maintaining the recovery: peer support groups, problem-solving groups, emotional management courses, educational and career development programmes, art programmes, volunteering opportunities. In contrast to hostels, which deal with a larger number of service users who have mental health and substance use problems and therefore have mental health support workers, GP drop-ins and provide information about a lot of local services and activities, there was a general agreement that very little happens in refuges. As one survivor described: “*In refuge, there were no activities going on. They did have a children’s worker who took kids for an hour. When I left there were activities about getting a job...[but] if they know someone has mental health issues, need to make sure there’s stuff for them, not just bring them in and do nothing.* (details withheld)

Conversely, there are multiple drawbacks to living in hostels or the other accommodation which survivors who have drug, alcohol or mental health problems are usually referred to. Firstly, they are not as safe as the address is not withheld and security measures in the building are not always as comprehensive as a refuge. Secondly, women may be required to live with their children in B&B accommodation that can also feel unsafe and are often in bad condition which leads women to return home. Finally, hostels do not usually allow children under the age of 18 which means some women may choose to leave their children at home. Direct access accommodation, other than refuges, is also very difficult to access. In Bristol, for example, in order to be placed overnight in a hostel or B&B, individuals need to attend an appointment at the Council House to be assessed. There are only four direct access bed spaces in the City for women who use or drink problematically or have mental health problems and need to leave home in an emergency. The huge difficulties in accessing alternative accommodation means many survivors with these additional needs will be deterred from leaving an abusive partner.

7) The detrimental impact of waiting lists

Unfortunately, access to many services – from drug treatment to specialist sexual violence counselling services and refuge provision is limited. There is insufficient

provision to meet the needs of survivors, and particularly for specialist counselling, clients commonly wait up to a year to be seen. A long waiting list can reduce the likelihood that the client will eventually take up the service. As one interviewee in Nottingham advised workers:

“If someone is in that mindframe, there’s not point saying wait three weeks, you might forget, you might not get the letter. You need to grab people quick, if they’re in that frame of mind.”

In one refuge, a survivor described being turned away from the local IAPT service with the advice to find a voluntary sector counselling service that had a six month waiting list. In the meantime, she does not feel she can burden her friends or key worker with everything that is going on in her head and so her mental health is deteriorating.

Delaying access to services can also have widespread consequences, such as a survivor in Nottingham whose alcohol support contacted the SPMHI co-ordinator for advice about specialist counselling services for her client. The client had been sexually abused in her past and it is clear that this is hampering her progress in relation to her alcohol use. The client is under pressure from Children’s Services to improve her lifestyle, but she feels unable to without dealing with her experiences of sexual violence first. Due to the long waiting times for specialist counselling, this survivor is at risk of losing her child before she is able to access the support she needs.

8) The value of peer support

As already noted, survivors positively rate the support they receive from peer-led groups such as harm minimization and anxiety management groups run by drug and alcohol and mental health organisations. As one focus group participant in Bristol said, *“There’s nothing better than engaging with someone who has a shared experience”*. This quote reflects the more widely expressed belief that only other survivors understand the reality of experiencing abuse and the recovery process:

“The word recovery isn’t about drugs, it’s a way of life, it’s recovering from DV [domestic violence], it’s a cycle of trying to get out” (Bristol focus group)

“It’s not just about physical violence. Beat me as much as you want, I can recover from that. But I’ve still got the mental and emotional scars that I haven’t recovered from” (Bristol focus group)

“People really don’t understand the consequences of not letting go. [Professionals] don’t really get it and don’t help you with it. If you do not let go, your life is never going to change. That person will ruin your life and your life is never going to change. Letting go is the bravest thing in the world. Let go and never look back” (Bristol focus group participant)

Survivors also felt that, in comparison to services, with other survivors you can be yourself more: *“You have to present yourself as vulnerable in order to get any support [from services], if you present as strong and well, the response is different than if you were a mess, crying and sobbing and weak”*. Furthermore, peers are less likely to judge you for appearing to be strong and understand you still need support,

as opposed to services that have the following approach: *“if you’re too assertive, you have too much strength to be taken seriously”* (Bristol focus group participants).

Interestingly, many of the survivors said that a good practitioner is one who is not just your worker but also a friend. For several survivors, the only person they really ever spoke to was their key worker in either drug and alcohol or domestic violence services. On reflection, it appears this desire for a friend highlights again the need for practitioners to treat service users as human beings rather than just another case with a file full of paperwork. Furthermore, it echoes the existing knowledge that survivors of domestic and sexual violence, and particularly those survivors with additional needs, feel very isolated and do not have a wide social network to rely on. The need for peer support around a particular issue, or simply opportunities to develop friendships is therefore paramount:

“Loneliness gets the better of you. I have nothing and no one in my life. So I go and see him” (Bristol focus group participant)

“It’s been nice to be around people who have experienced the same things, to develop friendships” (Hounslow interviewee)

“I love being able to talk to my keyworker about EastEnders. It’s like I’m not just a recovering addict, I am a human being and there is something in my life other than staying in recovery” (Nottingham focus group participant)

9) The need for childcare

Childcare, or the extensive lack of it, remains a key barrier to accessing support for all three issues. Survivors who participated in the consultation repeatedly noted ways that the lack of childcare meant they were unable to enter treatment for substance use, unable to attend support groups to remain drug- or alcohol-free and unable to attend counselling or therapeutic support groups:

“[I have a] 9 month old baby, only just got childcare sorted through health visitor with a community grant, it’s only ten weeks, so only just coming back to group. Because of the current economic climate, no services are providing childcare.” (Nottingham interviewee)

“[Gaps in services are] advice for mothers, things they can take their children to, group for people with mental health problems who are parents, even with the crisis team it was hard to talk about how I was feeling in front of my daughter.” (Nottingham interviewee)

“I am waiting on CBT now...but they make no provision for childcare so I will have to pay for my own childcare. So that means I gonna have to pay for it in town [as there is no childcare near the CBT appointment venue]” (Nottingham interviewee)

As well as hampering women’s recovery, survivors also noted that the lack of childcare leaves women very isolated and therefore more vulnerable to continuing to experience all three issues:

“It’s something the Government should be looking at. They keep saying they are looking at recovery and stuff, but it’s a huge problem for women. It’s so

isolating, for women because it's mainly the women who look after the kids. Even if you have a couple, and the guy's not got a job it still falls down to the women. They go out and do their thing. It's a nightmare situation to be stuck in the house. You feel trapped, you can't get out, and although you can ring people, it's not the same. That's what I've tried to do...it's difficult if you're on the phone and the baby starts crying. The best solution would be one crèche for all the services, in the middle of town, close to everything." (Nottingham interviewee)

Recommendations

Practitioners

Consider the importance of the relationship between you and your service users. Being non-judgemental, simply listening and understanding, being reliable by keeping appointments and carrying out agreed tasks, and most of all being human.

Remember the importance of small acts of kindness such as offering service users a drink, trying to make contact if you cannot make an appointment or are running late.

Be aware of your own limits – offer support where you can and know when to refer on.

Provide service users with information about possible services, including self-help or peer support groups. The lack of information about support and activities was highlighted particularly by women staying in refuges.

Conversely, do not overwhelm survivors with too much information, too many appointments or pressure to engage with lots of services.

Service providers

All staff need training on how to work with survivors of abuse who may have additional needs relating to problematic substance use and/or mental health problems.

Refuge staff need additional training to be able to support service users with drug, alcohol or mental health problems, and also require organisational support to ensure that service users are offered sufficient support to address their additional needs and maintain the safety of the refuge for all residents.

Ensure staff have access to information about other services. Where possible, facilitate opportunities for staff to visit services to develop relationships that will ease referral pathways.

Whilst not explicitly stated by survivors consulted for this report, it is vital that staff are provided with sufficient line management and clinical supervision to ensure they are supported to work with these complex cases. It is evident from some survivors' experiences that staff are not always sure of what action to take and, more worryingly, staff regularly appear hostile towards women who are vulnerable due to their experiences.

Local commissioners and policy makers

Officials with responsibility for commissioning talking therapies, such as specialist counselling services and IAPT services, must consider the needs of the local population who do not meet the thresholds for primary and secondary mental health services. Additional funding to expand IAPT provision to people with more complex mental health difficulties would be highly welcome, as would funding to reduce waiting times for specialist services for survivors of domestic and sexual violence.

Ensure service providers, particularly GPs, have easy access to information about local services and relevant referral pathways to aid referrals between services.

Urgent consideration needs to be given to providing appropriate accommodation-based services to survivors of domestic and sexual violence who have also been affected by substance use and/or mental ill-health. This provision needs to be flexible, allowing survivors with additional needs to be safely housed in a service that can provide the necessary support.

Affordable and easily accessible childcare for women with a range of needs, including drug and alcohol treatment, mental health problems and experiences of domestic and sexual violence, should be more widely available. Without childcare, many women will be unable to engage with services that are key to their recovery and will therefore create a greater burden on health and social budgets.

Central Government

Promote the roll-out training of the Royal College of GPs e-learning package to all GPs on domestic and sexual violence, and extend the training to highlight the links with substance use and mental illness.

As the responsibility for IAPT transfers from the Department of Health to the NHS Commissioning Board during the current four-year plan to expand the remit of IAPT services to more severe mental health issues, action should be taken to ensure all IAPT services are provided with clear guidance on how to routinely enquire about domestic and sexual violence, and how to respond to survivors and perpetrators.

The NHS Commissioning Board should issue clear guidance to Clinical Commissioning Groups about the need for specialist therapeutic support services – from helplines for victims of domestic and sexual violence, specialist counselling services such as Rape Crisis and specialist trauma services, for example the Trauma Centre in Nottingham – and the benefits of commissioning these services.

In line with the recommendations in the pending Stella Project refuge mapping report, local commissioners should ensure that service specifications for domestic violence refuge provision include specific provisions in relation to supporting women who have substance use and mental health problems, including realistic funding to provide this service. Furthermore, joint commissioning should also enable greater partnership working between drug and alcohol, mental health and domestic violence service providers to increase practitioners' confidence in working with these issues.

The NHS Commissioning Board should remind Directors of Public Health (once in post), Police and Crime Commissioners (once in post) Mental Health and Drug and Alcohol Commissioners and Clinical Commissioning Groups about the Health Inequality Duty and that, due to women's general role as main caregiver, the non-provision of childcare contributes to an inequality between women and men in access to healthcare services such as drug and alcohol treatment and mental health services.

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fit psychiatrist Women understand
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worker go around
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something medication
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Services women's went change live emotional like
enough needs recovery police referral
contact person phone relationship massive Hounslow
present work child social doctors lot
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use doctor experience Bristol left stay keep
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take health first places always
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