

A Way Through the Woods:

Opening Pathways to Mental Health Care for Women with Multiple Needs

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Abstract

Purpose	<i>This paper reports on a pilot project that helps women offenders and other women with multiple needs to access mental health care. The paper aims to increase understanding of the mental health needs of these women and barriers that they face in accessing and sustaining engagement with appropriate care.</i>
Design / approach	<i>Key principles and early findings are presented from the partnership project based in Anawim women's centre, in which a mental health nurse is seconded to the centre one day a week. These are presented in light of research relating to the mental health needs of vulnerable women.</i>
Findings	<i>Early findings suggest mental health needs are largely trauma-based and co-occurring substance misuse problems are common. The mental health nurse negotiated a pathway into secondary care with Community Mental Health Team managers but concerns continue about the ability of primary care services to meet the complex needs of these women. Principles for working with this group include: provision in a women-only space; a focus on engagement; flexibility; holistic support; and empowering women and voluntary sector staff.</i>
Research limitations	<i>Findings are based on eight months of one pilot project in which 22 women were seen.</i>
Practical implications	<i>Practical implications are outlined for commissioners and service managers of mental health care services for vulnerable women.</i>
Value	<i>Research and experience suggest that women with multiple problems can struggle to engage with traditionally structured services and fail to access the holistic support they need. This article increases understanding of this problem and suggests how these women might be better supported.</i>

Key words: Women, Offenders, Multiple needs, Complex needs, Trauma, Mental Health

Category: Case study

Introduction

Research has consistently found high levels of co-occurring mental health and substance misuse problems among women offenders (Gelsthorpe et al, 2007) and other groups of vulnerable women, such as the homeless (Reeve et al, 2006). Plugge et al (2006) found that 78% of female prison reception assessments showed some level of psychological disturbance compared to just 15% of the general adult female population. In addition 75% of women prisoners had taken an illicit drug in the six months prior to imprisonment. Plugge et al (2006) compared this to figures for the general population which suggest that only 12% of the general population had taken an illicit drug in the previous year. In many instances these women experience multiple co-existing problems such as poverty and debt, unemployment, experiences of violence and abuse, physical health problems and problems managing (often single) parenthood. Women with such multiple needs often struggle to access appropriate mental health support (Reeve et al, 2006; Corston, 2007) or sustain engagement and compliance once support is accessed.

Equality legislation places a duty on public bodies to take steps to meet the specific needs of women, considering how the design of services may impact upon women's ability to access them (Equality and Human Rights Commission, 2011). The previous government's women's mental health strategy (Department of Health, 2002a) recognises their distinct needs and highlights specific vulnerable groups, including women offenders, where morbidity is higher than for their male counterparts.

Corston (2007), in her review of women in the criminal justice system, demands "a fundamental re-thinking about the way in which services for this group of vulnerable women, particularly for mental health and substance misuse in the community are provided and accessed" (p.2). Bradley's (2009) review into people with mental health problems and learning disabilities in the criminal justice system offers support for Corston's conclusions and highlights the importance of early intervention and prevention for those at risk of mental health deterioration. In addition, he highlights the need for improved services for people with a dual diagnosis of mental ill-health and substance misuse. Although published under the last administration, the new Government has indicated some support for both 'landmark reports' (Lord McNally, 2010), particularly for the mental health liaison and diversion services advocated in the Bradley report (HM Treasury, 2010; Ministry of Justice, 2010).

Factors such as rigid appointment systems, complex service structures and a single-issue approach to needs mean that people with multiple problems can struggle to engage with some traditional statutory support (Rosengard et al, 2007). However, such women often engage with voluntary sector agencies, albeit interspersed with periods of non-engagement or imprisonment. More than half of the women (1,125) who have accessed the women's community projects have engaged for longer than three months (APPG on Women in the Penal System, 2011). Corston described this as, "an impressive achievement given that some projects have only been running since as late as March 2010" (p.2).

Consequently, a partnership approach between statutory mental health services and the relevant voluntary sector agencies offers an opportunity to reach out to these women, as recognised in the women's mental health strategy and implementation guide (Department of Health 2002a, 2003). This article describes one such partnership approach: a pilot project based in Anawim women's centre in Balsall Heath, Birmingham. A mental health nurse (MHN) from a dual diagnosis service was seconded to the centre one day a week. There she assessed women's mental health needs and supported them to access appropriate care.

Anawim

Anawim is one of a number of voluntary sector-run women's centres around the country, the national roll-out of which was a key recommendation of the Corston report. Anawim's mission statement says that "It seeks to provide positive choices to help [women and children] achieve their goals and reach their full potential as part of the wider community... Anawim seeks to work with partners and other agencies to challenge that which degrades and diminishes women" (Anawim, 2010, p.1).

Anawim acts as a one-stop shop of services for women with a variety of complex problems and needs. In 2009/10, 339 women attended the centre, or its subsidiary centre in Lozells. On arrival, the women undergo initial assessment covering the range of their needs and are linked in with the agencies that can provide appropriate support.

A total of twenty-seven different external agencies come into Anawim to provide support around issues such as drugs, housing and benefits. There is an in-house counselling service; creative therapies such as embroidery; educational courses; social activities; a crèche for children under five; and food and clothes can be obtained at the centre.

Women can self-refer and Anawim receives referrals from a range of agencies. In addition they undertake street outreach and outreach in two women's prisons. Clients include a growing number of women who have committed an offence and who are sentenced by the courts to undertake unpaid work or a specified activity at the centre. This brings women into the centre that may not traditionally have been linked in with any services and provides an invaluable opportunity to engage and support them.

The pilot

Revolving Doors Agency is a charity that works to change systems and improve services for people with multiple needs, including poor mental health, who are in contact with the criminal justice system. Our work includes policy and influencing, development work and service user involvement.

In 2007 Revolving Doors embarked on a series of pilot projects in partnership with local organisations to test out a range of approaches to working with this group. Together they formed the Revolving Doors National Development Programme (NDP). The NDP was a development process designed

specifically to overcome the challenges of working with a hard-to-engage group. It worked at three levels: identification of needs, demonstration of solutions, and shaping policy and commissioning. Following initial meetings with West Midlands Offender Health Team and other local partners, it was agreed to focus the work in the West Midlands on the women using Anawim.

Staff at Anawim observed that many of the women appeared to have some form of mental health need and/or had had previous contact with mental health services. However, current contact with these services was rare, and where occurring did not always appear to be meeting needs. Although Anawim has a counselling service (not open to people with severe and enduring mental health problems), prior to the pilot there was no in-house support from primary care or mental health services and Anawim staff lacked knowledge or confidence to be able to help these women access the mental health support they needed.

A steering group was convened consisting of representatives from Anawim, Birmingham and Solihull Mental Health Foundation Trust, Revolving Doors Agency, NHS West Midlands, the Pan Birmingham Mental Health Commissioning Team and the National Offender Management Service West Midlands.

A MHN from the dual diagnosis field was seconded one day a week to Anawim. Her primary role was to assess the women's mental health needs and help them to access appropriate support. Anawim staff referred women to the MHN and women could self-refer or approach the MHN informally around the centre. The MHN also approached one woman in the centre who was visibly in distress.

In total, 22 women were seen by the MHN during the first eight months of the project, with the MHN speaking to other women informally at the centre. An 'emotional wellbeing' group attended by 14 women was also held. Additionally, four brief training modules were conducted with Anawim staff to increase their confidence and capacity to assist these women to access appropriate care.

The needs of the women

In her review into women in the criminal justice system, Corston considers these women in terms of their vulnerabilities, which she classifies as: **domestic**, such as domestic violence or being a single-parent; **personal**, such as mental illness or substance misuse; and **socio-economic**, such as poverty, isolation and unemployment. She concludes that "when women are experiencing a combination of factors from each of these three types of vulnerabilities, it is likely to lead to a crisis point that ultimately results in prison." (Corston, 2007, p. 2)

A report from the Fawcett society highlights an analysis of data from OASys, the national offender assessment tool, which suggests that "a key characteristic of women offenders is the likely presence of multiple presenting problems" (Gelsthorpe et al, 2007, p.17). The report cites further evidence that many problems, particularly poor mental health/emotional stability and poor self-esteem are more prevalent amongst women offenders than their male counterparts.

Box 1: Other needs identified by Anawim

These include:

- drug use, often poly-drug use
 - homelessness, temporary or unsafe accommodation
 - children in care or at risk
 - debt and chronic financial situations
 - poor communication and social skills
 - negative peer groups and inappropriate relationships
 - low educational achievement, chronic unemployment, low aspirations
 - poor self-image and self-care
 - little or no family support
- (Doal & Pound, 2008).

Evidence emerging from women's centres supports Corston's findings and offers a detailed picture of the complex and entangled needs of these women (Box 1). "Ministry of Justice statistics gathered from women community projects data show that almost half of the women referred to the projects have needs in more than four areas: 48% have drug or alcohol problems, 40% have experienced domestic violence, sexual abuse or rape and 8% are involved in prostitution" (All Party Parliamentary Group on Women in the Penal System, 2011, p.2).

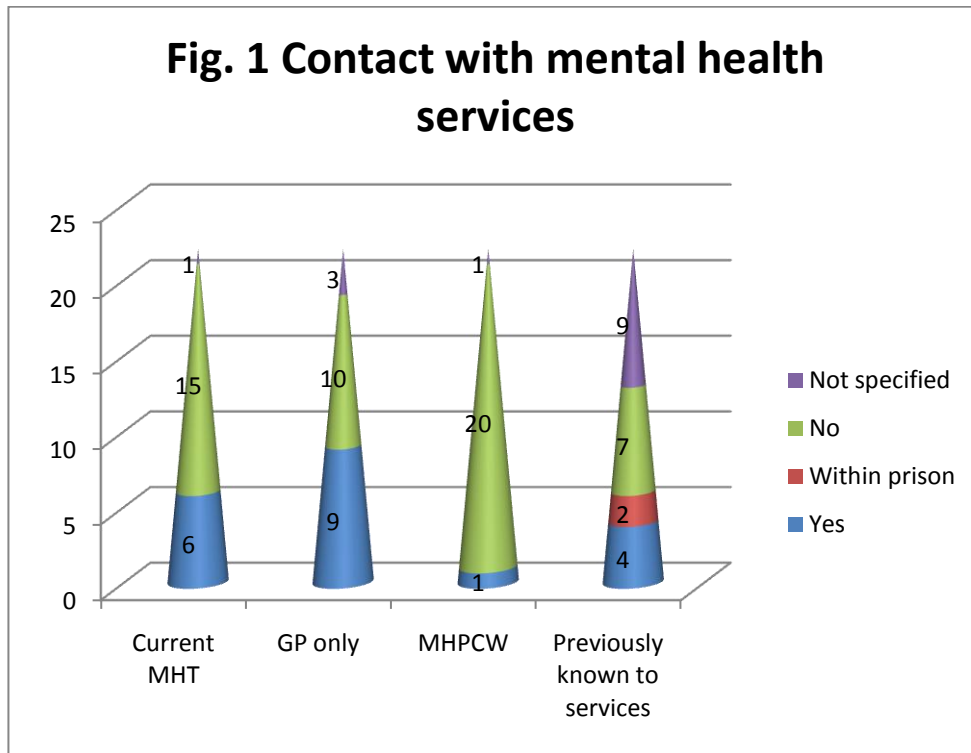
Case Study 1:

Henna is an Asian woman who had an arranged marriage and suffered several years of domestic violence before fleeing the relationship with her two children. Her family disowned her, leaving her isolated. She struggled to bring up her children alone and her health deteriorated. She was working less than 16 hours a week and mistakenly believed she was entitled to claim a specific benefit. She was convicted of benefit fraud and sent to Anawim on a 60 day specified activity order. She has engaged continuously, undertaking counselling, art and craft activities, and college

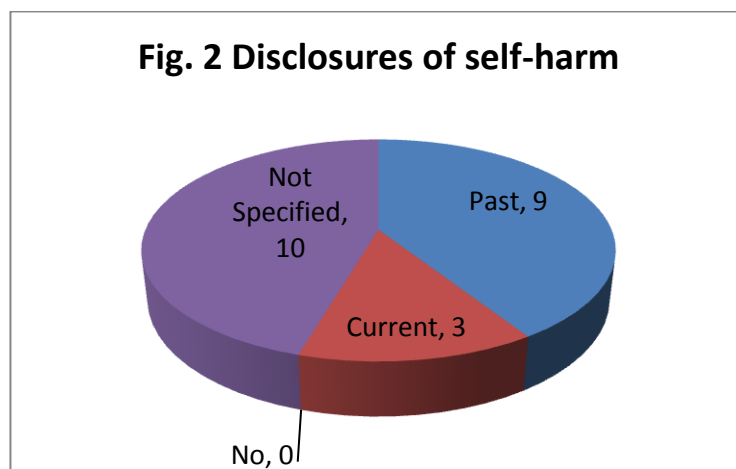
Mental health

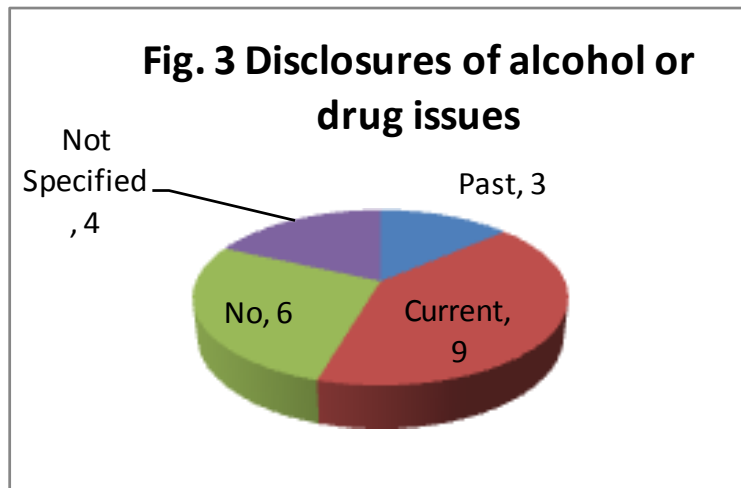
During the MHN's assessment, emphasis was placed on the women's current issues and the issues that they wanted help with. Consequently, some information, particularly historical, is not available for all the women seen.

Six of the 22 women were found to be currently involved with mental health services while nine women were seeing their GP for help. One woman was seeing a primary care mental health worker (Figure 1).

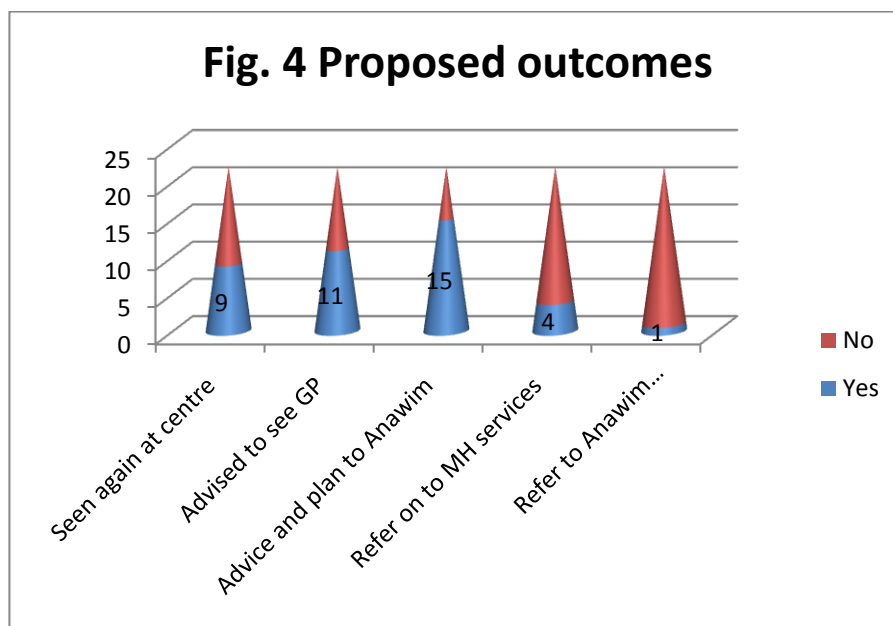


Eight of the women were being prescribed medication, predominantly anti-depressants but in one case an anti-psychotic, and in another a benzodiazepine. In addition, four women had previously received medication for mental health problems. Of the 18 women who specified, two-thirds (12) disclosed a difficulty with drugs or alcohol, and in nine cases this was a current difficulty. Of the 12 women who described a history of self-harming, three were current (10 did not specify). See Figures 2 and 3.





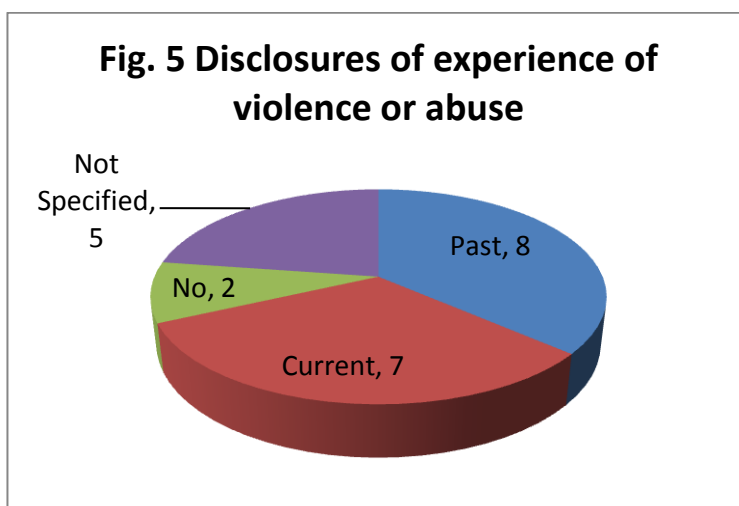
Outcomes of engagement were that four women were considered appropriate for referral to secondary mental health services, while 11 were advised to return to their GP. One woman was referred for counselling at the centre. In other cases, support was offered by the MHN at the centre or advice and a care plan was given to the woman's Anawim key worker (Figure 4).



The MHN has contrasted the mental health needs of these women with those of clients traditionally encountered on community mental health team caseloads. Few of the women she has encountered at Anawim have a psychotic illness; instead, mental health problems for the majority are trauma-based such as anxiety, complex post-traumatic stress disorder (PTSD), depression and in some cases personality disorder.

The importance of trauma

Of the 17 women who chose to specify, 15 disclosed experiences of violence and abuse. For seven of the women these issues were current (Figure 5). In 14 cases, the violence and abuse took place in the home.



Women are more at risk of violence and abuse than men in both childhood and adulthood and there is evidence of a link to long-term mental illness (Department of Health, 2002a). In addition, women who misuse substances are more likely to have experienced sexual, physical or emotional abuse than other women or men (Department of Health, 2002b).

Research suggests a high number of women from vulnerable groups have experienced violence, abuse or other trauma. Clinical observations indicate a high prevalence of early neglect and abuse in the homeless population (Maguire et al 2006). Of 134 homeless women surveyed by Reeve et al (2006) 60.4% had experienced domestic violence and 49.3% had experienced other forms of abuse. They also identified other traumatic experiences in the histories of homeless women such as loss of children and bereavement. A review of evidence gathered by the Cabinet Office (2010a) for Inclusion Health cites a study suggesting that 68% of women sex workers meet the criteria for PTSD, similar levels to those found amongst victims of torture or combat veterans.

Problems accessing mental health care

Considered in isolation, the mental health problems experienced by these women are often of a mild to moderate severity which could be managed within primary care, particularly once the national roll-out of the Improving Access to Psychological Therapies (IAPT) programme is complete. This programme aims to increase access to cognitive-behavioural self-help exercises and where necessary Cognitive Behavioural Therapy for those suffering from anxiety and depression (Centre for Psychological Services Research, 2010; Department of Health, 2011). However, Anawim's experience is that primary care

services often struggle to manage women with multiple and complex needs. Inclusion Health highlights that “Socially excluded clients often have a longstanding mistrust of services and may not understand or engage in appropriate ways. For mainstream practitioners, it can be hard to tune into the complex needs of socially excluded groups and allocate sufficient time and tailored interventions to meet the complexity of their needs.” (Cabinet Office 2010b p.13) Support from primary care mental health workers can be time-limited and does not provide sufficient opportunity to build a rapport and explore traumatic and long-standing issues.

Lawrence (2006), exploring dual diagnosis in primary care, highlights the complex and dynamic relationships that exist between psychiatric and substance misuse disorders, and the increased risk of co-morbidity; i.e. a range of problems that need addressing in addition to mental health and substance misuse. Lawrence draws on National Treatment Agency guidance emphasising that “it is important that primary care practitioners know the level of co-morbidity their service can deal with, when to ask for additional support and the referral procedures for the appropriate specialist services. In addition, if the patient is not under the care plan [sic] approach there should still be a form of care plan and coordination” (p.142). This suggests that the primary care practitioner has a role to play facilitating coordination between care providers.

Even for those six women who were in contact with secondary mental health services, treatment was usually as an outpatient and care constituted a twenty minute appointment with a psychiatrist, quarterly; again, insufficient opportunity to build a therapeutic relationship and explore complex problems. Only one was aware that she was subject to the Care Programme Approach.

Many of the women at Anawim struggle to manage compliance with medication and inflexible appointment-based systems due to the often chaotic nature of their lives, adopting multiple roles and facing multiple problems. Other research into multiple and complex needs has highlighted problems that appointment-based systems can pose for chaotic groups (Rosengard et al, 2007). A study of the self-reported experiences of health services among female street-based sex workers (Jeal & Salisbury, 2004) found that 52% of the 71 women surveyed found waiting for available GP appointments difficult, whilst 51% struggled to keep appointments made.

“As some of the best services have demonstrated, chaotic lifestyles do not have to mean chaotic care. But in the absence of suitably flexible and responsive services, chaotic lifestyle can frequently mean unplanned and expensive care.” (Cabinet Office, 2010b, p.26) Some women at Anawim reported histories of repeat crisis presentation at accident and emergency departments (A&E), followed by discharge without follow-up. This echoes the description from the National Institute for Mental Health in England (NIMHE) of the experience of personality-disordered patients who are “treated at the margins – through A&E, through inappropriate admissions to inpatient wards...They have become the

new revolving door patients, with multiple admissions, inadequate care planning and infrequent follow-up.” (NIMHE p.13)

Staff attitudes also play a role in the poor service experience of these women. 45 percent of 71 street-based sex workers interviewed by Jeal & Salisbury (2004) found attending the GP's surgery difficult because they felt judged by staff, while research into experiences of personality-disordered patients suggests poor staff attitudes towards this group (Castillo, 2009).

Healthcare practitioners can fail to understand the underlying causes of poor presenting behaviour. Maguire et al (2006) describe how “Early abusive experiences can result in difficult thought processes and rumination and concomitant intolerable emotions. The easiest method of altering these, in the short-term at least, is to take some form of substance, i.e. drugs or alcohol... Where more adaptive interpersonal skills have not been learnt, more destructive ones which have previously been successful to some extent (e.g. aggression) are used.” (p.125) The complex and often interpersonal nature of the problems “means that interpersonal interactions can be difficult due to inherent ambiguities in human communication and sensitivities of clients associated with childhood neglect and abuse. Some may interpret others’ attitudes as rejecting and neglectful easily, and become depressive or angry, behaving accordingly.” (p125)

Principles of the pilot

Women-only space

Reeve et al (2006) suggest homeless women are more likely to engage with services which feel ‘safe’ and provide women-only spaces. Action research into services for women offenders conducted with the Together Women Project, which provides women’s centres in the North West and Yorkshire and Humber, found that “All stakeholders and staff interviewed believed that women required a different approach and that such provision needed to take place in a women-only environment, particularly because so many women had a history of abuse and were often current victims. This view was endorsed by the women themselves.” (p.9)

The implementation guide to the women’s mental health strategy calls for Primary Care Trusts “to ensure that there is provision for women to have access to a network of women-only community day service support” (Department of Health, 2003, p.29).

Engagement

Many of the women had poor previous experience with services and were wary or mistrustful. Engagement with these women was key. The MHN had been seconded from a dual diagnosis team and prior to that had experience in assertive outreach, both areas with a focus on engagement. She utilised the Cognitive Behavioural Integrated Treatment Approach (Graham 2004) in which engagement constitutes the first treatment phase.

The Dual Diagnosis Good Practice Guide (Department of Health, 2002b) describes how “Engagement is concerned with the development and maintenance of a therapeutic alliance between staff and client. The strength of this alliance will depend, in part, on the value a client attributes to the service. This can be enhanced by the style of interaction, which should be non-confrontational, empathic and respectful of the client’s subjective experiences of substance misuse. The therapeutic alliance will also benefit from meeting a client’s immediate needs rather than focusing on the cessation of substance misuse.” (p.20).

Anawim offers practical services useful to the women. The MHN possesses a positive, non-stigmatising attitude and interacts informally with the women around the centre; for example, eating lunch with the women. Discussion of mental health issues is largely on the women’s own terms with emphasis on immediate needs.

Holistic and integrated care

The women’s mental health strategy emphasises that “Ultimately [women] want services to adopt a ‘whole person’ approach to their care, treatment and rehabilitation, to value their strengths and abilities and to recognise their potential for recovery, in the context of holistic assessment and care planning.” (Department of Health, 2003, p.10) Holistic care is particularly important for women who experience such a range and depth of co-existing problems. Reeve et al (2006) suggest that “A more integrated approach to meeting women’s needs is required, joining-up services which homeless women would benefit from” stressing in particular that “this should include sexual and domestic violence, substance misuse and mental health services.” (p.8)

Assessment at the centre spans the range of the woman’s needs. Occasionally, where necessary, the MHN has sat in on these assessments to ensure mental health support is incorporated from the outset. The multiple agencies that go into Anawim enable problems that precipitate and exacerbate mental ill-health to be addressed in a coordinated manner. Notably, support with drug and alcohol problems is available through the centre. As well as facilitating access to psychiatric care, the MHN is able to link women with the full range of centre services. Considering such alternatives routinely is recommended within the women’s mental health strategy (Department of Health, 2002a, 2003).

Flexibility

One clear problem for these women was inflexible services, particularly in relation to appointments. Unfortunately, but perhaps unsurprisingly, nine women failed to attend their follow-up appointment with the MHN. However, several returned at a different time for follow-up and were able to engage with the MHN, formally or informally at the centre. Additionally, training from the MHN enabled Anawim workers to offer increased support when the MHN was not available.

Case Study 2:

Gill presented to the Anawim MHN in crisis with suicidal ideation. She was homeless, having previously struggled to cope in her flat, and had a history of crisis admissions to psychiatric hospitals followed by discharge without follow-up. The available GP at Gill's surgery did not know her and suggested that she attend A&E; the MHN accompanied her. Despite having experienced a recent incident of sexual violence and expressing the particular wish to be seen by a female doctor, she was initially seen by a number of male doctors. After five hours the psychiatrist arrived, who was also male, which distressed Gill further. She was asked to wait another two hours for the home treatment team, who transferred her to an inpatient psychiatric ward. Next morning, the ward manager explained that the consultant was considering discharging the woman. The MHN expressed her concern that this was repeating an unhelpful pathway for the woman. The ward manager changed the decision and the woman remained for three weeks on the ward as an informal patient. During this period the MHN and project coordinator both liaised with inpatient staff. Following this liaison, discharge was ultimately followed up by home treatment and subsequent transfer to the community mental health team. (West Midlands Offender Health, 2010)

Empowering staff and women

Although not the primary aim of the pilot, the MHN believed that mental health support for women attending Anawim would be aided by empowering staff to offer support themselves. The implementation guide to the women's mental health strategy highlights this opportunity for mutual learning between voluntary and statutory sector agencies, recognising the voluntary sector as "a valuable source of expertise in the improvement of statutory services" who could conversely "benefit from accessing relevant training delivered by the statutory sector" (Department of Health, 2003, p.12).

Following a training needs assessment, the MHN offered four training sessions to the staff: understanding personality disorder; the structure of mental health services and referral pathways; understanding mental health difficulties; and commonly used medications.

The women's mental health strategy also advocates consideration of mental health promotion as part of gender sensitive service planning (Department of Health, 2002a). As part of the pilot, the

MHN offered an 'emotional wellbeing' workshop to all women at the centre, to help them take responsibility and control over their own mental health. This workshop covered lifestyle balance, securing emotional health and coping strategies. This enabled women to share their own experiences and for many provided their first opportunity to speak about experiences of personal or familial mental ill-health. Participation and feedback was extremely positive and several of the women stayed behind after the session to engage with the worker on a one-to-one basis.

Negotiating appropriate care pathways

Initially, when secondary mental health care was appropriate, the MHN requested that the woman's GP refer the woman to the relevant service. However, one early case study (Case Study 2) suggested in some cases it would be necessary to accompany the woman along the pathway, to ensure sustainable long-term support was achieved.

Despite the MHN's achievements in this difficult case, it was clear that such pathways into mental healthcare were unhelpful and unsustainable. Subsequently, the MHN and the project co-ordinator presented this case study at the Community Mental Health Team managers' meeting and gained agreement that the MHN could refer directly to mental health services where she thought appropriate and this referral would be accepted. This established a clear care pathway for Anawim women in need of secondary care, although referral routes through the GP were still used where possible.

In this, the MHN was helped by her extensive local knowledge of mental health teams and a network of professional contacts gleaned as part of her regular work in a dual diagnosis team which provides consultancy and training to mental health teams across the Birmingham area. Accessing services was more problematic when women presented to the centre from outside the area. The MHN considered this knowledge to be crucial to the success of the pilot.

Discussion

Women's centres cater for women with multiple and complex needs. Evidence from Anawim highlights the sheer variety and number of needs experienced by many of these women, a finding supported by other research into female offenders, sex workers and homeless women. One important outcome from the pilot was an increased understanding of their mental health needs and how the complexity of their problems impedes their ability to access and engage with services in the expected manner.

The pilot has offered an insight into how these women might be helped to access mental health support as part of a holistic approach to addressing their problems. Successful outcomes include engaging formally with 22 'hard-to-reach' women and many more informally; agreeing a pathway into secondary care with Community Mental Health Team managers; four referrals into secondary care and 11 into primary; and the improved confidence and capability of Anawim staff to address mental health need.

Three factors stand out as key to the success of the project: the partnership; the location; and the MHN.

The partnership: The pilot arose from concern by a number of agencies that a group of particularly vulnerable women were not accessing mental health care. These agencies shared a desire for change and expressed a willingness to work together to find a solution, recognising that "to ensure equality of access and outcome there is sometimes a need to do something different" (West Midlands Offender Health, 2010, p.5).

The Anawim centre provides a safe, women-only environment which adopts a recovery-focused approach emphasising the women's strengths and offering them opportunities to build on these in a supportive environment. As a one-stop shop it ensures interventions to meet all the woman's needs are integrated.

The mental health nurse has been crucial to the project's success having shown an appetite for working with a group of women whose presenting behaviour can be difficult and whose traumatic experiences can be distressing for staff. As a MHN her assessments of mental health need had credibility and her referrals legitimacy with other mental health professionals. Her professional background – in assertive outreach and a dual diagnosis consultancy team – has provided her with skills to engage these women and an invaluable local knowledge that has resulted in excellent pathway navigation. Despite this, accessing appropriate mental health care for these women was not always easy and required an ability to think creatively.

The project has highlighted continuing concerns about the care of women who do not meet the criteria for secondary mental health care but whose level of co-morbidity makes them a near-impossible challenge for primary care. Such concerns are reflected elsewhere. For example, clients with complex needs were specifically identified as a challenge in terms of caseload and time availability for practitioners involved in the IAPT development sites (Centre for Psychological Services Research, 2010). It is clear that better co-ordination between primary care workers and the local women's centre may go some way to addressing the needs of this group. Even within secondary mental health services, a more holistic approach to the woman's needs aided again by increased co-working and clear care coordination is demonstrably required. Unfortunately, at the time of writing, long-term funding has currently not been secured for the network of women's centres, raising doubts about the future of such an approach.

The Equality Duty places responsibility on local services to identify and respond to the needs of groups who are failing to receive an equitable service but who may have high levels of need. This pilot offers some initial insights into needs and suggests that a relatively small investment can lead to considerable improvement for a group of women who are currently being failed.

Implications for practice

- Women in the criminal justice system frequently have a dual diagnosis of mental ill-health and substance misuse along with multiple co-existing problems.
- Women with multiple needs struggle to access and engage with traditionally-structured services.
- Poor care-coordination and discharge planning can result in repeat crisis presentation.
- Mental health services in both primary and secondary care should consider how they can best support patients with dual diagnosis and multiple co-existing problems.
- Voluntary- run women's centres are good facilities to identify and engage with a 'hard to reach' group and can provide holistic support to these women. Partnership approaches should be considered.
- Key principles of working with this group include women only spaces; a focus on engagement; holistic and integrated care; and empowerment.
- Mental health issues are largely trauma-related and staff should be appropriately trained and enthusiastic about working with a group whose histories can be distressing and behaviour difficult.
- Good care navigation is essential but challenging, and good local knowledge and an ability to think creatively are crucial.

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