#### Mental health and service access for survivors of VAWG in Scotland

### Results from SafeLives survey, October 2021

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| Research questions |
| 1. To what extent does experiencing Violence Against Women and Girls (VAWG) impact on the mental health of survivors?
2. How accessible are mental health support services to survivors of VAWG and how has this been impacted by the Covid-19 pandemic?
3. What are the key factors that will help to ensure women receive the support they need at the time they need it moving forward?
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##### Overview of respondents

* 111 women answered the full survey from 24 of the 32 Scottish local authorities. Largest concentration of responses from North Lanarkshire (10), Perth & Kinross (10), Glasgow City (9).

###### Demographics (See Appendix for tables with full breakdown of respondents)

* All respondents were female assigned at birth apart from one who preferred not to state their sex. In terms of gender, almost all identified as women - one identified ‘in another way’, one as non-binary, and one preferred not to say.
* The most frequent age of respondents was 40-44 years old. Two in five (39%) respondents were aged 35-49. Almost a fifth (18%) were over 55 and a small proportion (4%) were under 25.
* The majority of respondents identified as heterosexual (83%); 13% identified as lesbian, bisexual or another sexual orientation.
* The majority of respondents identified as White British/Scottish/Irish (89%); 5% described themselves as White – Other and 5% were from Black, Asian or racially minoritised backgrounds.
* Just over a quarter of respondents had a disability (27%). The most common type was mental health (79%), physical (55%), neurological condition (21%), progressive illness (21%).

###### Experience of abuse

* The most type of VAWG experienced by respondents was domestic abuse (74%) within an intimate or romantic relationship. As shown in the table below, about half of respondents had experienced sexual harassment, rape or sexual assault, or abuse in a family relationship. A fifth (22%) had experienced child sexual abuse. Small proportions had experienced selling/exchanging of sex or ‘honour’ based violence.

|  |  |  |
| --- | --- | --- |
| Experience of VAWG | n | % of all |
| Violence or abuse in an intimate/romantic relationship | 82 | 74% |
| Sexual harassment, bullying or intimidation | 59 | 53% |
| Rape / sexual assault | 55 | 50% |
| Violence or abuse in a family relationship | 50 | 45% |
| Child sexual abuse | 24 | 22% |
| Selling or exchanging of sex | 3 | 3% |
| 'Honour based' violence | 1 | 1% |

* The majority of women were not **currently** experiencing VAWG (85%). At the time of answering the survey, 14% were experiencing a form of VAWG.
* Three quarters (77%) of women had experienced **multiple forms** of VAWG. The average number of types experienced was 2. A fifth (22%) had experienced four or more types of VAWG.

##### Mental health and the impact of VAWG

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| --- |
| Key findings |
| The majority of respondents said their mental health need started after their experiences of VAWG and that the experiences had a severe or moderate impact on their mental health.Women experienced multiple types of mental health need. Anxiety, depression, and sleep difficulties were most common. Two thirds had experienced suicidal thoughts and almost a quarter identified suicidal behaviour.Alongside mental ill health, women were frequently experiencing other issues, most commonly physical health difficulties, difficulties in other relationships, financial problems and employment issues. A third identified problematic alcohol use, and a tenth both alcohol and drug use. |

* Most frequently, women identified experiencing **anxiety** (93%). Two thirds (67%) had experienced suicidal thoughts and almost a quarter identified suicidal behaviour (23%). The types of mental health need respondents said they had experienced are shown in the table below.

|  |  |  |
| --- | --- | --- |
| Types of mental health need | n | % of all |
| Anxiety | 103 | 93% |
| Depression | 94 | 85% |
| Trouble sleeping | 88 | 79% |
| Low self-esteem | 87 | 78% |
| Feelings of hopelessness | 85 | 77% |
| Suicidal thoughts | 74 | 67% |
| Emotional instability / sudden changes in mood | 74 | 67% |
| Panic attacks | 73 | 66% |
| Problems with eating | 62 | 56% |
| Flashbacks | 51 | 46% |
| PTSD | 49 | 44% |
| Self-harm | 44 | 40% |
| Suicidal behaviour | 25 | 23% |
| Obsessive compulsive disorder | 23 | 21% |
| Other | 9 | 8% |

* On average, the women answering the survey identified having experienced **eight types** of mental health need.
* Over three quarters (78%) of women said their mental health need started **after** their experiences of VAWG.
* In terms of the strength of impact of VAWG, more than half (57%) said it **severely** impacted their mental health and almost one third (30%) said it had a **moderate** impact.
* The majority of survey respondents had been experiencing poor mental health since **before the Covid-19 pandemic** (88%), i.e., for more than 18 months.

###### Additional needs

* Along with mental ill health, 92% of women identified having at least one **additional support need** whilst they were experiencing VAWG. The table overleaf gives a breakdown of these needs.
* On average, women had three additional needs alongside mental health and VAWG. More than one third (35%) had four or more additional needs.
* Most commonly, women had needs related to their physical health (57%) or their relationships with family and friends (56%).
* One third (32%) of women identified problematic alcohol use, and one in eight (12%) had experienced problems with both drug and alcohol alongside their mental health need.

|  |  |  |
| --- | --- | --- |
| Additional needs alongside mental health | n | % of all |
| Physical health | 63 | 57% |
| Relationships with adult family members / friends | 62 | 56% |
| Finances / debt | 48 | 43% |
| Employment difficulties | 42 | 38% |
| Alcohol use | 35 | 32% |
| Parenting / relationships with children | 30 | 27% |
| Housing / homelessness | 26 | 23% |
| Drug use | 19 | 17% |
| **Both drug and alcohol use** | **13** | **12%** |
| Other | 4 | 4% |

##### Accessibility of mental health support

|  |
| --- |
| Key findings |
| The majority of respondents had attempted to access a mental health service, but only just over half of those who attempted went on to receive a service. Including those who had not attempted access, half the survey respondents said they had not received mental health support.By far the most common way women initially attempted to access mental health support was through their GP. For the women who access a service, more than half received a service within six months of requesting support whilst two in five waited more than six months.Women who received mental health support overwhelmingly said it had a positive impact, though some commented on support not being trauma-informed, domestic abuse aware, or too slow and time-limited. Some women had to pay for private counselling due to waiting times.Women who accessed a mental health service were more likely to say they had also accessed other forms of support, such as through a domestic abuse service, family and friends, online resources, or self-help books.The most common barriers to support access identified by women were doubt that their needs were significant enough and shame. Waiting lists, visibility of services and professional enquiry were also key issues.Women want to see freely and quickly available mental health support, with a range of therapeutic options to suit individual needs. Service provision should be women centred, VAWG literate and trauma informed. Women said that increasing the visibility and broadening access options for mental health services, as well raising awareness of mental health and VAWG, would improve service access.  |

###### Routes to support services

* The majority (87%) of women had **attempted to access** a mental health service at least once. One third (33%) had attempted more than once and one in eight (12%) had not attempted.
* As shown in the table overleaf, the majority of those who tried to access a service went to their **GP** to discuss getting support (92%). It was also quite common to talk to family and friends. A fifth (19%) sought support via helplines and the internet.

|  |  |  |
| --- | --- | --- |
| Where did you go to discuss getting support? | n | % who tried |
| GP | 87 | 92% |
| Family or relative | 37 | 39% |
| Friend or neighbour | 25 | 26% |
| Domestic abuse service | 22 | 23% |
| Helpline | 18 | 19% |
| Internet | 18 | 19% |
| Sexual abuse service | 16 | 17% |
| Hospital-based health professional | 14 | 15% |
| Work colleague | 11 | 12% |
| Police | 11 | 12% |
| Health Visitor/Family Nurse | 10 | 11% |
| Addiction service | 5 | 5% |
| Children & Families Social Worker | 4 | 4% |
| Adult Social Worker | 2 | 2% |
| Housing worker | 1 | 1% |
| Other | 10 | 11% |

* Just over half (55%) of the women who attempted to access a service did go on to **receive** mental health support. One third (34%) did not receive any support and a small proportion (7%) were on a waiting list.
* The graph shows the proportions of survey respondents, overall, who tried to access support and did access support. Including those who were on a waiting list at the time of responding, 47% of respondents had not accessed a mental health service, either because they had not attempted it or had, and had not been referred or gone on to take up the support.

###### Experiences receiving mental health support

* Of those who accessed some kind of mental health support, the most common type was **one-to-one counselling** they were referred to (62%), as shown in the table.

|  |  |  |
| --- | --- | --- |
| What sort of service? | n | % who accessed |
| 1:1 counselling / therapy sessions (referred) | 32 | 62% |
| GP support | 25 | 48% |
| 1:1 counselling / therapy (private / paid for) | 22 | 42% |
| Community Mental Health Team | 16 | 31% |
| Charity-based support / groupwork | 12 | 23% |
| Community Psychiatric Nurse (CPN) | 9 | 17% |
| Online self-help course | 9 | 17% |
| Psychiatric In-patient Ward | 6 | 12% |
| Therapeutic groupwork (private / paid for) | 3 | 6% |
| Peer support service | 3 | 6% |
| Other | 3 | 6% |
| Intensive Home Treatment Team | 2 | 4% |

* More than half of the women who received a service were **referred by their GP** (58%) whilst almost two in five **self-referred** (37%).
* As shown in the table below, over half of those who accessed support received a service within 6 months of requesting support (56%), with two fifths waiting for more than 6 months (42%).

|  |  |  |
| --- | --- | --- |
| Time between seeking support and accessing mental health service | n | % who accessed |
| Less than a month | 16 | 31% |
| 1-3 months | 5 | 10% |
| 3-6 months | 8 | 15% |
| 6-12 months | 8 | 15% |
| 12-18 months | 6 | 12% |
| More than 18 months | 8 | 15% |
| Don't know/remember | 1 | 2% |

* For those who accessed a service, the majority (76%) felt a **positive impact** on their mental health as a result:

|  |  |  |
| --- | --- | --- |
| Impact of support on mental health | n | % who accessed |
| Improved greatly | 20 | 38% |
| Improved slightly | 20 | 38% |
| No change | 7 | 13% |
| Decreased slightly | 1 | 2% |
| Decreased greatly | 2 | 4% |

###### Survivors’ words – experiences receiving mental health support

Women who had received support from a mental health service had the opportunity to comment on their experience. Positive comments described the support as lifesaving and highlighted how it had made them feel empowered and less alone.

**It saved my life and made me more capable of supporting myself**

**It was beneficial, just so hard to ask for help during relationship because they were regarding as someone doing well and I should be so grateful - the support allowed me to be myself, take control of my life and was like a long needed breath of fresh air.**

 **When I receive support I feel less: alone, weird, terrified, worried, powerless, worthless.**

Other comments described less helpful experiences, often linked to support not being trauma-informed, domestic abuse aware, or too slow and time-limited.

**There is little awareness that Post traumatic stress is a result of domestic abuse.**

**more tailored support, with adjustable timeframes - for example some individuals could benefit greatly from 12 sessions, whereas some people (such as myself) really only begin to scratch the surface of things and it would be nice if these services weren't just providing a small number of sessions and then just sending people out there to try and cope on their own (or pay for further treatment which not everyone can afford)**

**The waiting times were too long that I tried to commit suicide on more than one occasion or self harmed. I was left waiting for hours to be assessed and having the police. I feel Let down and failed**

Some women paid for private counselling due to the waiting times for NHS services or as a result of previous experiences.

**Wait for NHS support has already been 10 months and I have another year to wait until I am seen. I have accessed private support as I am unable to work and didn't want to continue alone with flashbacks, panic attacks and nightmares especially with a police investigation ongoing and the potential of going to court.**

**My experiences of mental health care within the NHS have been wholly negative and I hope very much never to need to access these services again. By contrast, paying for therapy has been a stretch financially, but has been generally positive and has helped me improve my mental health significantly and to cope with things better in the long term. I think this is primarily due to being able to select people with better training and with relevant specialisms, and to a lesser extent, due to being able to pick people I have clicked with.**

######  Accessing other forms of support

* All respondents were asked what **other forms of support** they had accessed, apart from mental health services. The table shows the most common types:

|  |  |  |
| --- | --- | --- |
| Other sources of mental health support | n | % all |
| Friend or neighbour | 62 | 56% |
| Family or relative | 49 | 44% |
| Self-help books | 38 | 34% |
| Domestic abuse service | 28 | 25% |
| Online self-help resources | 28 | 25% |
| Sexual abuse service | 20 | 18% |
| Helpline | 11 | 10% |
| Community group | 5 | 5% |
| Live chat service (online) | 4 | 4% |
| Other | 10 | 9% |
| Prefer not to say | 2 | 2% |

* Women who accessed a mental health service (n=52) were more likely to have also accessed other types of support. This may indicate higher levels of need, or it may demonstrate how women linked into mental health support are signposted to other sources of support. The table below shows a comparison between women who did and women who did not access a mental health service:

|  |  |  |
| --- | --- | --- |
| Other sources of mental health support accessed by respondents | % accessed | % did not access |
| Domestic abuse service | 35% | 12% |
| Sexual abuse service | 25% | 8% |
| Family or relative | 50% | 25% |
| Friend or neighbour | 63% | 25% |
| Community group | 6% | 2% |
| Helpline | 8% | 8% |
| Live chat service (online) | 2% | 4% |
| Online self-help resources | 31% | 13% |
| Self-help books | 44% | 17% |
| Other | 8% | 10% |
| Prefer not to say | 0% | 2% |

###### Barriers to support service access

* All survey respondents were asked what factors had prevented them getting mental health support when they needed it. The most frequent barrier was **doubting their needs were significant enough** to access support (68%) followed by **shame/embarrassment** (55%).
* Waiting lists (39%), a lack of awareness of services (35%), and professionals not asking about mental health (31%) were also common factors.

|  |  |  |
| --- | --- | --- |
| Have any of the following prevented you from getting mental health support when you needed it? | n | % all |
| I doubted whether my needs were significant enough | 75 | 68% |
| Shame or embarrassment | 61 | 55% |
| Waiting lists for local services were too long | 43 | 39% |
| I did not know what support was available | 39 | 35% |
| Professionals did not ask me about my mental health | 34 | 31% |
| I was unhappy with previous support I received | 21 | 19% |
| Services did not know how to help me | 16 | 14% |
| I was scared of losing my children | 16 | 14% |
| I was told my needs did not meet service thresholds | 14 | 13% |
| Delays in services accepting referrals due to Covid-19 | 10 | 9% |
| I felt unsafe accessing support due to violence/abuse | 10 | 9% |
| There wasn't a service in my local area | 5 | 5% |
| Services were not able to help with all my needs (e.g., substance use) | 6 | 5% |
| I felt unsafe accessing support due to the risk of contracting Covid-19 | 1 | 1% |
| Services were not inclusive of my identity(e.g., gender / sexuality / ethnicity / socioeconomic status) | 1 | 1% |
| Other | 9 | 8% |

* Amongst the small number (n=14) who said they were told their **needs did not meet services thresholds**, 86% (n=12) reported suicidal thoughts, 50% (n=7) reported suicidal behaviour, and 71% (n=10) had self-harmed. Amongst the small number (n=16) who said **services did not know how to help**, 88% (n=14) reported suicidal thoughts, 38% (n=6) reported suicidal behaviour, 81% (n=13) had PTSD, 88% (n=14) identified having emotional instability, and 88% (n=14) had panic attacks.
* Some of the ‘other’ responses were connected to concerns over privacy when accessing services; affordability of therapy; inability to take time off work for therapy; inappropriate options being offered, such as online only sessions during Covid-19 or groupwork options only; not being ready to access support.
* Reflective of the length of time respondents had been experiencing mental health needs, most had attempted to access support **prior to the Covid-19 crisis** (62%). Just over a third (36%) had attempted since the pandemic. Linked to this, small proportions of respondents in this sample identified Covid-related barriers to service access, as shown in the table.
* The smaller group (n=34) who had attempted to access support since the pandemic were slightly more likely to experience certain barriers:
* Not knowing what support was available (44% v 31%)
* Told needs did not meet thresholds (21% v 12%)
* Waiting lists too long (44% v 37%)
* Delays in services accepting referrals due to Covid-19 (26% v 2%)
* Feeling unsafe to access support due to violence/abuse (15% v 7%)

###### Survivors’ words – Improving access to mental health support

All women answering the survey were asked what would have made it easier to access mental health support when they needed it. The diagram below shows the categories of answers to this question, the size of each section indicates how frequently that answer came up in responses.



**What would have made it easier for you to access mental health support when you needed it?**

Service availability was the strongest theme in the answers. Unacceptably long waiting lists prevented women from accessing support when most needed. Availability was also discussed in terms of longer opening hours and more services to physically access. More funding to increase the availability of current services, but also to expand the range of options available was key here.

**Shorter waiting times, more than CBT being offered**

**A service that is open 24/7 with physical presence available, like a centre.**

**if it was better funded therefore more robust - more councillors [sic] available to take on patients, reduced waiting times (I was told it would be an 18-month w[a]it before covid was even [a] thing, covid then made it take over two years before i started receiving support. I don't mean to sound dramatic but that kind of waiting time could be literal life or death for some people and I dread to think of the consequences of that)**

Being more informed about services and the support available was another clear theme in the answers. Knowing what services do, but also what to expect from mental health support, was important here.

**More information about where and what help I can get**

**Knowing what to expect when seeing someone, after being on a waiting list for so long people lose hope and then when they do see professionals not much can be done to help especially eupd [emotionally unstable personality disorder]**

The theme of awareness was about people having a greater understanding of the connection between gender-based violence and mental health, to reduce time taken to establish needs and appropriate responses. Comments covered professional, societal and self-awareness.

**Professionals understanding the extent of abuse Nobody asked about the domestic abuse my family was suffering. It was all about prescribing anti depressants**

**For professionals to see beyond my drug use and recognise my mental health problems and the affects [sic] of trauma**

**I don't really know - probably more overt information when I was younger that forcing some one to perform a sex act WAS sexual abuse. There was nothing I ever saw growing up that expalined [sic] that it was. The ME TOO movement made me see things in a different way. So specific bigger public awareness raising would help.**

**Did not relate my past problem with my current mental health until accessed service. Perhaps more awareness needed how this can effect [sic] people.**

A more appropriate GP response was an important element for many women. This was about GPs being more understanding and empathetic, more informed about pathways to support, and less inclined to medicalise mental health needs and not consider the causes of trauma.

**From the first contact with my GP […] I was not persuaded to access support but instead given antidepressants. If the GP had encouraged me to receive CBT or something similar I believe my situation could have been better.**

**I first told my gp about my childhood sexual abuse and how it was impacting my mental health at an appointment with my 3yr old and 3 month old present. They referred me to online self help titled 'beating the blues'. I found this so upsetting and dismissive. I didn't have blues, I had complex PTSD which went on unchecked to seriously impact my relationship with my youngest.**

**Mental health being considered alongside physical health at general gp appointments**

Some comments described the kind of attitude and approach from professionals that could have better facilitated a route to mental health support. Being believed about abuse and being listened to and taken seriously was important here. One respondent discussed sexuality and inclusivity and the importance of services having an approach that is appropriate for different survivors.

**If any of it was not generically heterosexual. Every time I phoned anywhere (GP, MENTAL HEALTH, COUNSELLING, WOMENS AID ETC) they all asked if my husband was still living with me and if it was ongoing abuse from him. Every one of those services has an inclusive policy re different sexualities etc yet every one of them assumed it was a man who had been abusing me. So, every single time I had to 'come out to them' and explain my sexuality etc. This was definitely a barrier for me.**

Stigma was another theme, with shame and fear of judgement described as barriers to service access.

**I felt like I was a burden and very embarrassed by my problems and my inability to get things right […] I think society seeing mental health support as normal and requesting support as something anyone might need (like going to A&E with an injury) would have helped me.**

Finally, direct access was discussed with some women calling for more options to access mental health services through self-referral or means other than GP referral.

**HV [Health Visitor] direct referral rather than having to go through GP.**

**Being believed that I needed it. Not having to have my police report confirmed to access support. Not having my requests denied by GPs.**

###### Survivors’ words – Looking to the future

All women answering the survey were also asked what mental health support they wanted to see available to women and girls in the future. The diagram below shows the categories of answers.



**What mental health support would you like to see available for women and girls in Scotland in the future?**

First and foremost, women again emphasised the important of timely & appropriately funded mental health support, with freely available counselling. Some highlighted the importance of early intervention, with funding available for schools to address VAWG and mental health from an earlier age.

**IMMEDIATE. Not so long after breaking point that everything is endangered or lost.**

**More funding given to the people who already work in schools with girls, because they are already in situ and can pick these 'cases' up much more easily.**

The importance of a range of therapeutic options to meet women’s needs was also key. Adjustable timeframes and formats were discussed. Some women called for more affordable or accessible private therapy options for those for whom paying was an option. Some discussed the importance of options other than medication.

**Support that is about the whole person and their life - not just the symptom or problem that the NHS is only interested in. Support to help me deal with my issues and get a decent life rather than medication to dull me and make me feel hopeless about the future.**

**Some therapy type sessions which didnt involve sitting in a straight backed chair across from a man in a straight backed chair. Why not go out for a walk and talk?**

**Easy access to mental health assessments and a choice of treatment to suit their personal needs and circumstances.**

Comments categorised under ‘women-centred’ called for single sex services for women, and also for services fully versed in the specifics of women’s health issues, e.g., perinatal mental health, and social issues.

**Single sex services are vital. I couldn’t possibly speak about what has happened to me with anyone male.**

**Gender based discussion by knowledgeable therapeutically trained other women - like whats ok and whats not ok.**

**A dedicated team of mental health professional for women & girls perhaps in gp health centres, hospitals, homeless units & refuges.**

Women wanted to see mental health support that is more visible and easier to access. This was often about the advertising of services, the time-of-day services are available, their physical place in the community, and for several, having the option to access online or by text. Improving assessment and referral processes to ease access was also important in this.

**Informed responses from GPs, referrals to mental health specialists […] proper marking of records so that GPs or professionals are aware of your history or current status so they are alert to issue/look for other issues arising**

**Easier accessible help and support - more knowledge on what happens if and when you require the support and/or seek it. Text message service for convenience- therefore number can be saved as alternative name for the victims safety**

Awareness and education, particularly for younger women, of mental health needs and VAWG was another theme in the responses. Awareness-raising for wider society to reduce the stigma and shame associated with mental ill health and VAWG was part of this.

**I think there should be awareness raising sessions at school and college level. Including who to turn to for support or to report a matter. I didn’t consider myself to have been a victim of sexual harassment/abuse until I was much older as at the time I didn’t understand what was happening to me. If I had, I think I would have been more likely to seek help sooner.**

Finally, women emphasised the importance of VAWG and trauma informed provision, both specialist services and informed understanding approaches in wider sectors.

**Dedicated trained compassionate professionals who have a true understanding of the dynamics of abuse.**

**Trauma informed education and health care settings and professionals who recognise and respond to adversity and trauma responses.**

**Widely available and accessible, trauma informed mental health care, especially targetting marganalised groups and communities. A feminist approach to mental health; I don't mean pushing a feminist agenda to people accessing services, but rather having a service that acknowledges the impact on girls and women of having to exist in a society that is misogynistic - that has high levels of violence and abuse against women and girls, that expects them to conform to limiting and silencing gender roles, and that punishes those who don't.**

##### Appendix 1

###### Demographic data tables

Total respondents: 111

|  |  |  |
| --- | --- | --- |
| Sexuality |  |  |
| Heterosexual or straight | 92 | 83% |
| Bisexual | 9 | 8% |
| Lesbian/Gay | 2 | 2% |
| Any other sexual orientation | 3 | 3% |
| Prefer not to say | 5 | 5% |
| **Total LGB** | **14** | **13%** |
| Total who answered | 111 |  |

|  |
| --- |
| Age |
| 20 to 24 | 4 | 4% |
| 25 to 29 | 13 | 12% |
| 30 to 34 | 14 | 13% |
| 35 to 39 | 11 | 10% |
| 40 to 44 | 17 | 15% |
| 45 to 49 | 15 | 14% |
| 50 to 54 | 16 | 15% |
| 55 to 59 | 11 | 10% |
| 60 to 64 | 7 | 6% |
| 65+ | 2 | 2% |
| Total who answered | 110 |  |

|  |  |  |
| --- | --- | --- |
| Ethnicity |  |  |
| White - British | 24 | 22% |
| White - Scottish | 72 | 65% |
| White - Irish | 2 | 2% |
| White - Other | 6 | 5% |
| Arab | 1 | 1% |
| Asian/Asian British - Pakistani | 1 | 1% |
| Black/Black British - African | 2 | 2% |
| Mixed - White and Asian | 1 | 1% |
| Chinese/Other Ethnic - Chinese | 1 | 1% |
| Prefer not to say | 1 | 1% |
| **Total Black, Asian and racially minoritised** **inc. White Other** | **12** | **10%** |
| Total who answered | 111 |  |

|  |  |  |
| --- | --- | --- |
| Type of disability |  | % Total with disability |
| Mental health | 23 | 79% |
| Physical | 16 | 55% |
| Neurological condition | 6 | 21% |
| Progressive illness | 6 | 21% |
| Learning disability | 2 | 7% |
| Sensory disability | 2 | 7% |
| Other | 2 | 7% |
| Learning difficulty | 1 | 3% |
| Organ specific | 1 | 3% |

|  |  |  |
| --- | --- | --- |
| Disability |  |  |
| No | 73 | 68% |
| Yes | 29 | 27% |
| Prefer not to say | 6 | 6% |
| Total who answered | 108 |  |

##### Appendix 2

###### Other comments questions

At the end of the survey, all respondents had the chance to leave any other comments. Twelve respondents were directed straight to this last question as they were not women with mental health needs who had experienced a form of VAWG.

Many of the comments here again underlined themes already discussed in this briefing, namely the importance of properly funding and resourcing mental health services, reducing waiting times, and broadening access options and therapeutic options.

**What little services there are are poorly advertised, simply not referred (or are denied), have damaging, absurdly long waiting lists and are often not long enough for any great change; they are one-size-fits-all and the requirement criteria are appalling. We need free/low income activities and therapeutics, and access to safe spaces to share and support each other.**

Some comments highlighted the systemic inequalities that respondents’ felt were tied to both VAWG and a lack of appropriate provision for women. One respondent highlighted the survey itself as an example of continuing exclusion of racially minoritised groups.

**The majority of women I have worked with (which is hundreds over the years) cannot engage in a survey such as this due to language barriers and digital exclusion. Some of the most highly vulnerable women are actually completely excluded from all sorts of important research and resulting strategic decisions and services. Service planners and decision makers continue to disadvantage this group by continuing to use witten [sic] and online methods as key methods for research purposes. This is a form of systemic discrimination that needs to be challenged and overcome if we are to include and identify the mental health needs and provide adequate, appropriate support for all vulnerable women and girls in scotland.**

**Patriarchy has been proven to be toxic to women (and other genders!) but it is still prevalent in society. It’s time more action was taken on breaking gender stereotypes for example. There needs to be tougher actions to limit toxic comments made in public too. Misogyny is rife and there is no consequences - despite it playing a huge part in the well-being of women.**

The importance of having women centred services, including single sex spaces, again featured in responses to this question.

**Women and men's needs are different and that needs to be recognised**

Reflective of themes throughout the survey answers, one respondent again discussed the importance of improving women’s experiences with GPs.

**People's main support for their mental health is their GP, they're your first port-of-call. If I'm being honest, I've been traumatised by several GPs and their lack of empathy and understanding/interest in mental health support. I think GPs need some really intensive training so they can stop causing more harm than good and prescribing the wrong medication or overprescribing. There needs to be a more holistic approach to mental health instead of just writing a generic citalopram prescription (which doesn't help everyone) and sending people on their way**

Awareness and education was again a key theme in the other comments section, reflective of the whole survey.

**There needs to be a shift in societal thinking re gender based violence, if can educate from early years and not tolerate gender based stereotypes portrayed in the media it may have a knock on effect to prevent gender based violence in the first place rather than mopping up the effects afterwards.**

**More specialised prevention work and awareness training needs to be offered to girls from a young age to encourage more self awareness in women facing all these complex issues.**