National Women's Council of Ireland
Comhairle Náisiúnta na mBan in Éirinn

# Out of Silence

## Women's mental health in their own words

HSE

hi Healthy Ireland

# Out of SILENCE

## Women's mental health in their own words

November 2018

# Contents


Acknowledgements 2

Foreword 3

Executive Summary 6

Introduction 7

- Impact of Gender on Women's Mental Health 7
- Women's Mental Health in Ireland 11
- Mental Health Services and Policy – Irish Context 14

Methodology 16

- Background to the Project 16
- Aims and Objectives 16
- Study Sample and Participants and Recruitment Process 16
- Research Design and Data Collection 17
- Key Themes Identified 19
- Need for Further Research 21

Out of Silence: Women's Experiences 22

- Women's Experiences of Mental Health 22
- Expectations of Womanhood 25
- Social Determinants of Women's Mental Health 27
- Women's Mental Health at Different Life Stages 30
- The Diverse Experiences of Women 32

Out of Silence: Women's Call for Change 34

- Prevention 34
- Training 36
- Adequate Supports 37
- Access to Mental Health Services 38

Conclusion 39

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# Foreword

The National Women's Council of Ireland (NWCI) is the leading national women's membership organisation. NWCI is working towards a future in which women and men are treated equally. In our health work, NWCI is advocating for a health system that responds to the needs of women, upholds women's right to health and reduces health inequity between groups of women.

Improving mental health supports and services for women has been a major part of NWCI's health remit for over 40 years - that's because we know, through our direct contact with women, that mental health is a central issue in their lives. This is as a result of many factors such as the impact of gender stereotypes and roles, the pressure to conform, negative body image and instances of sexual harassment and abuse.

In this 'Out of Silence – Women's mental health in their own words' project we are seeking to break a sustained silence about women's specific mental health needs. We are bringing women's mental health issues 'out of silence' because they are often absent from the narrative about mental health in Ireland. We believe the best way to open up this conversation is to hear from women themselves about how they cope, how they keep themselves well and how they feel they could be better supported by services. Women's experiences must be at the centre of policy and decision making so as to ensure we have effective mental health services that meet the needs of women in all our diversity.

As NWCI Director, I want to sincerely thank all the women who participated in the conversations for their deep insights. We will strive to ensure that the commonalities and diverse experiences you shared with us are represented in NWCI's mental health policy and campaigning work.

**Orla O'Connor**
Director NWCI

# Executive Summary

We set out in the 'Out of Silence – Women's mental health in their own words' project to centre women's understanding of mental health – the things that keep women well, the social and community networks that support them and the services they turn to in times of difficulty.

In 2017/8 using NWCI's 'Out of Silence: Women's Mental Health in Ireland' film to frame our conversations, we engaged with diverse groups of women across the country to talk about their experiences of mental health and what supports their wellbeing.

This report focuses on the direct experiences of women in their own words. It was clear from the women we spoke to that their mental health is impacted by the gender inequality they encounter and by their life experiences. Clearly, how women move through the world and the experiences they face can influence the mental health issues they encounter and how they will seek support. In our conversations, women consistently talked about the challenges they faced, coping with multiple, intersecting demands on them – the need to 'look good', to achieve in work, to care for their family and to support their partners through their own hard times. Their stories further illuminate the impact of life events on women's wellbeing. Many women spoke about experiences of trauma in their early life, or catastrophic events in adulthood which stayed with them and influenced how they felt throughout their lives. Women from marginalised communities, including migrant women and Traveller women, spoke about the impact of discrimination and very poor living conditions on their mental wellbeing.

Five key themes impacting women's mental health emerged from across the conversations: women's experiences of mental health; expectations of womanhood; social determinants of mental health; mental health at different life stages; and the diverse experiences of women. As the women participants spoke about their experiences of mental health and wellbeing, they began to identify areas which they felt should be prioritised to support women. We document the calls for change identified by the women who participated. These priorities, which participants felt would ensure women are better supported to enjoy wellbeing and to feel cared for during times of mental health difficulty, are grouped under four broad themes: prevention; training; adequate supports; and access to mental health services.

# Introduction

The 'Out of Silence – Women's mental health in their own words' project aimed to document women's experience of mental health in Ireland. Women's experience of mental health and wellbeing has been largely absent from the broad discussion of mental health in Ireland, which has primarily centred on issues for young people and the high rates of male suicide. The limited attention paid to women's mental health has focused on mental wellbeing directly before and after birth, diminishing the different experiences of women throughout their lives.

This project, comprising conversations with more than a hundred women across Ireland, seeks to fill an important evidence gap, illustrating women's direct experiences of wellbeing and mental health. Often we look to personal stories as ways to open up understanding of an issue which has been kept silent. The foregrounding of women's voices in this project directly aligns with NWCI's values to frame our policy work around the experiences of women, to foster solidarity between women and to acknowledge the intersectionality of women's inequality with other inequalities related to class, ethnicity, sexual orientation and other identities.

Because of the impact of social determinants on health, in NWCI we believe that when we look at women's mental health we must simultaneously look at the structural inequalities which women face and which negatively impact their mental health. We must understand how health fits within the context of women's lives. As a result, any examination of women's mental health needs must reflect that women are more likely to be poor, to parent alone, to be the main provider of unpaid care work, to experience racism and discrimination, to be in precarious employment earning low wages and to be at risk of domestic or sexual violence.

## Impact of Gender on Women's Mental Health

We increasingly recognise an individual's health does not exist in a vacuum. Instead our mental and physical health is impacted by the conditions in which we are born, grow, live, work, and age. Gender is one of these social determinants of our health. The realities of women's lives, including society's expectations about how women should behave and look, mean that women can have quite different, specific mental health needs. 13% of female participants in the 2015 Healthy Ireland survey[1] indicated a probable mental health problem in comparison to 6% for males.

While mental health difficulties affect both genders, it is widely accepted that women and men are affected by different problems and experience them in different ways.[2] The table below summarises how gender can influence women's mental health differently to men.

1 Ipsos MRBI (2015) *Healthy Ireland Survey 2015- Summary of Findings*. Dublin: Department of Health.

2 Women's Health Council (2004) *Women's Mental Health: promoting a gendered approach to policy and service provision* and World Health Organisation (2001) *Gender Disparities in Mental Health*.

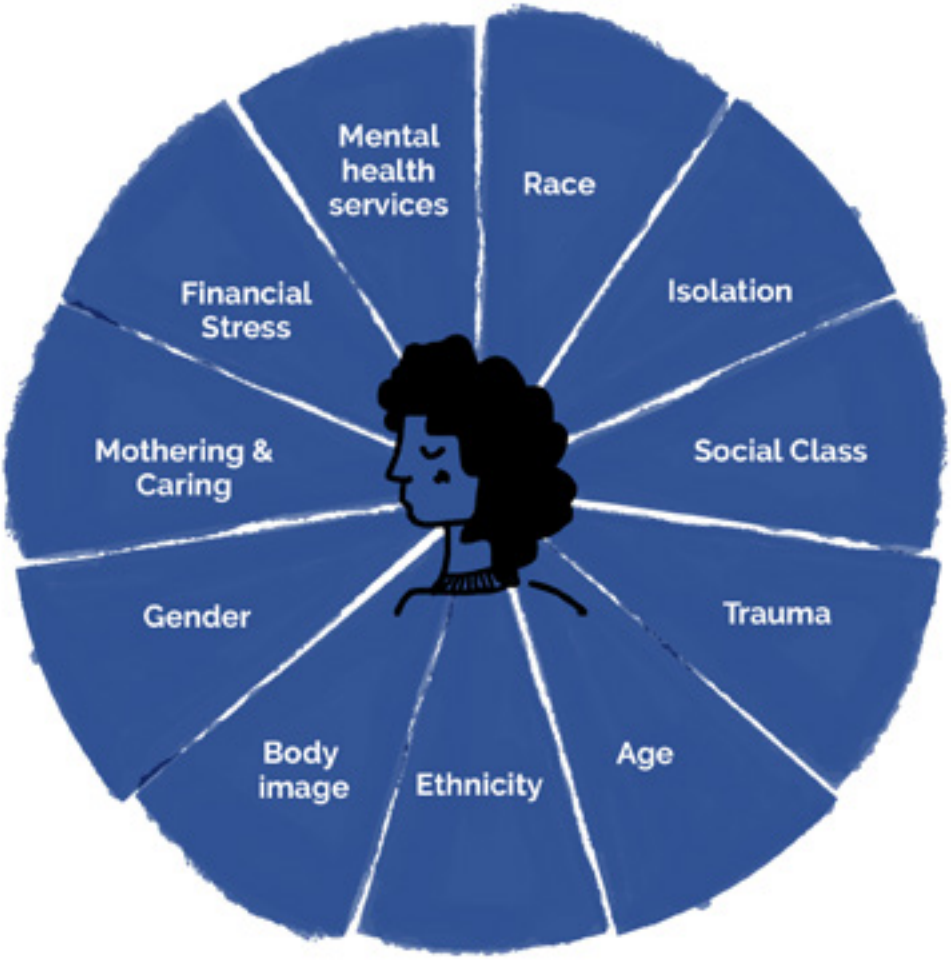
| Gender differences in mental health[3] | | |
|---|---|---|
| | **Women** | **Men** |
| **Life experiences** | Sexual & emotional abuse<br>Domestic violence<br>Caring responsibilities | Accidents, e.g. at work<br>Victims & perpetrators of violence<br>Social isolation<br>Homelessness<br>Prison |
| **Socio-economic Realities** | Poverty<br>Gender Pay Gap<br>Juggling demands of care & work<br>Backbone of caring services but few in leadership positions | Full-time employment<br>Unemployment<br>Retirement |
| **Expression of mental distress & symptoms** | Depression<br>Anxiety<br>Eating disorders<br>Self-harm<br>Perinatal mental health<br>Borderline personality disorder | Early onset psychosis<br>Suicide<br>Substance abuse<br>Anti-social personality disorder |
| **Pathways into services** | Primary care<br>Community services<br>Maternity services | Accident & Emergency<br>Drug/alcohol services<br>Criminal justice system |
| **Treatment needs and responses** | Community-based & informal (e.g. women's groups)<br>Gender-specific services<br>Greater risk of victimisation & exploitation | Activity-based (e.g. men's sheds)<br>Assertive outreach<br>Early intervention |

Many risk factors for mental health difficulties are experienced more frequently by women. The gender pay gap means women are more likely to experience in-work poverty. The pension gap leaves older women, who also suffer from higher rates of depression and dementia than their male peers, at greater risk of deprivation. Women have an unequal burden of care and household responsibilities, which can lead to significant stress and less time to participate in healthy lifestyle habits which promote wellbeing. Lower social status has been identified as a factor associated with mental health difficulties. Women are under-represented in political, leadership and cultural roles. Women are more likely to be affected by domestic and sexual violence and the resulting trauma can severely impact mental health. Media and society's obsession with how women look undermines the broad spectrum of what women have to offer, limiting how women engage with the

3 Table adapted from presentation by Dr. Karen Newbigging, Senior Lecturer in Health Policy and Management, University of Birmingham at NWCI 'Gender and Mental Health' Roundtable, November 2016.

world. Research[4] also shows that marginalised women (including asylum seekers, homeless women, Traveller and Roma women, LGBTQI women and women with disabilities) are disproportionately impacted by poor mental health.

## Factors impacting women's mental health




Gender differences also occur in women's patterns of seeking help and treatment. Women are more likely to seek help from their GP and in turn GPs are more likely to prescribe women medication rather than refer them to psychiatric services.[5] Getting access to mental health support is crucial. Yet women at the greatest risk, such as women in abusive relationships, or female refugees, may face more difficulty accessing help.

Women's wide-ranging responsibilities may be a real barrier to them entering mental health programmes or engaging with health services. Women can feel that they are holding up the world, balancing home and work stresses. Most women who use mental health services will have children and families for whose care they are responsible. The same women will often have major responsibilities in the workforce and to provide economically for their family.

4 For example see: Department of Justice (2017) *National Traveller and Roma Inclusion Strategy 2017-21;* HSE, Glen, BelongTo, TCD (2016) *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*; and Mental Health Reform & Simon (2017) *Homelessness and Mental Health: Voices of Experience.*

5 Women's Health Council (2002) 'Submission to the European Commission's Green Paper: Improving the Mental Health of the Population'. See also World Health Organisation 'WHO Gender Disparities in Mental Health'.

A woman's family responsibilities will often be a significant factor in whether and how a she will seek mental health support. A woman may feel that she will be judged as a mother and be concerned about the removal of her children if she seeks help. Or, she may actively seek out services but find that they aren't accessible for her because they don't provide for her family care needs.

Traveller, Roma and migrant women experience further difficulties accessing health services due to discrimination and unequal treatment. Roma and migrant women are often unable to access care because they do not meet habitual residency requirements. Those who do access services face additional barriers such as language. 53% of Travellers worry about experiencing unfair treatment from health providers.[6]

## Women's Mental Health Supports

When we speak about women's mental health there can be a tendency to think in terms of difficulties, obstacles and negative situations. But that isn't the full picture – we also need to foreground women's resilience, power and courage. This project was itself held-up by the courage and strength of women both in sharing their own stories and in meeting the mental health challenges they faced. We must also recognise that mental health is not all about mental illness. It is also about protecting wellbeing and mental *health.* Women themselves are seeking ways to stay well, accessing supports at community level, seeking counselling and networking with other women, including the use of social and cultural networks. Women support one another through informal supports - friendship groups, family, local women's groups through which they can share practical day-to-day needs like childcare, engage in community activities and education courses that provide social interaction, as well as in using women-only services such as domestic violence refuges.

Across Ireland, women's community groups support women's mental health in the broadest sense (through training, women's groups, childcare facilities, cafés, domestic violence services, etc.), as well as through the specialist services some of them provide. These services reflect the way in which women in communities across Ireland have identified their own needs and organised in response. It is vital that mental health services themselves become attuned to women's specific needs. This will require strong links with the networks of support for women in voluntary organisations, primary care and community mental health teams. Services need to take account of the day-to-day family, social and economic demands on women, including providing childcare facilities. To counteract the gender inequality faced by women, services should focus on self-esteem and empowerment, taking a holistic approach to wellbeing.[7]

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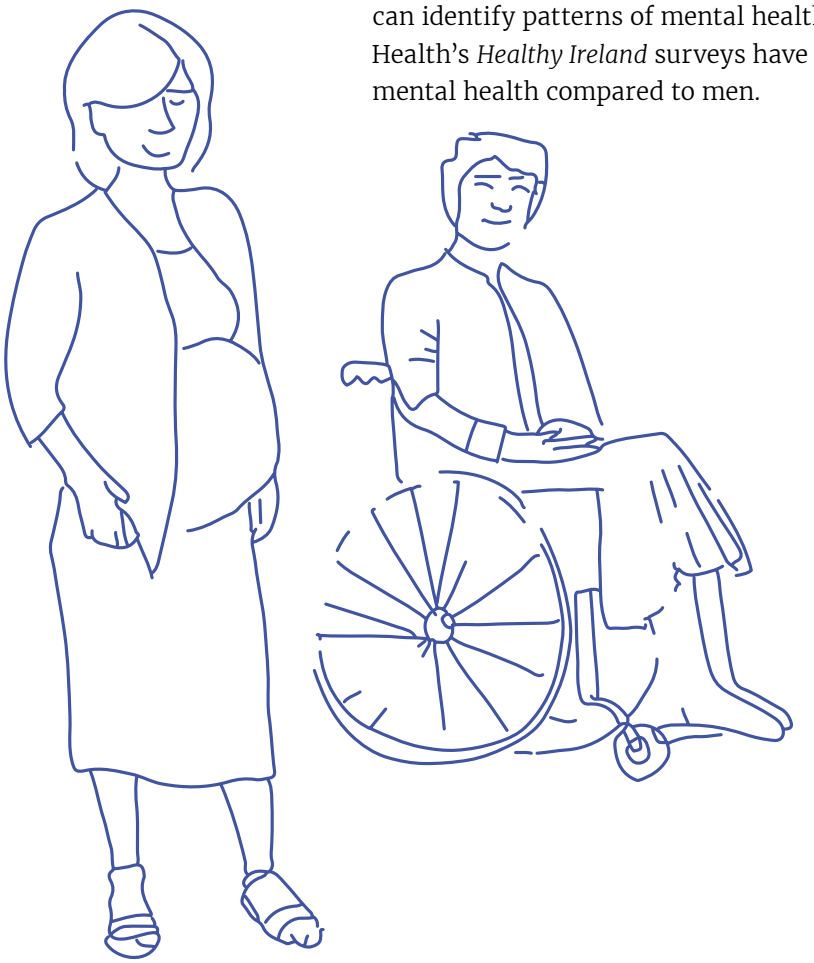
6 All Ireland Traveller Health Study Team (AITHS) (2010) *All Ireland Traveller Health Study: Summary of Findings.* Dublin: School of Public Health, Physiotherapy and Population Science, University College Dublin.

7 For more information on women-only mental health services see: UK Department of Health (2003) *Mainstreaming Gender and Women's Mental Health - Implementation Guidance.* London: Department of Health.

It is important that the mental health supports provided for women, in the community and in specialised mental health services, respond directly to women's needs. Mental health services often fail to acknowledge the social context of women's lives (e.g. poverty, racism, past and present abuse). This leads to women feeling branded as vulnerable and ill or as frail victims, rather than being recognised as extremely resilient in the face of adversity.[8] Women need mental health services in which they can feel respected and safe. Services that place importance on the underlying causes of their distress and not just the symptoms and that promote their empowerment and choices. To do this, services must address issues relating to women's roles as mothers and the need for accommodation and work and value women's strengths and abilities and the potential for recovery.[9]

## Women's Mental Health in Ireland

As shown by the World Health Organisation[10], globally the prevalence of many major mental health difficulties is higher amongst women, including depression, anxiety, anorexia and bulimia nervosa, somatic disorders and post-traumatic stress disorder. In Ireland, while research on women's mental health is limited we can identify patterns of mental health distress among women. The Department of Health's *Healthy Ireland* surveys have found women have lower levels of positive mental health compared to men.



8 Karen Newbigging (no date) *Supporting Women into the Mainstream – Commissioning Women-only Community Day Services.* Department of Health (UK)

9 For more information see Davies, J and Waterhouse, S. (2005) 'Do women need specific services?' in Nasser, M. *et al.* (eds.) *The Female Body in Mind.* Hove: Routledge.

10 WHO (2000) *Women's Mental Health: An Evidence Based Review.* Geneva: WHO

## Overview of women's mental health in Ireland

| | |
|---|---|
| **Young women** | In 2016, young women (15-24 years) were the group with the highest percentage of **negative mental health**.[11]<br>Ireland has the highest rate for **child suicide of girls** in the EU.[12] |
| **Suicide and self-harm** | More women than men **attempt suicide**, while men are more likely to die by suicide than women. The incidence of attempted suicide by females was 19% more than males.[13]<br>In 2016, the female rate of **self-harm** was 24% higher than the male rate. The highest rates of self-harm were amongst young women (15-19-year olds). One in every 131 girls in this age group presented to hospital in 2016 as a consequence of self-harm.[14]<br>Traveller women are dying as a result of suicide, at a rate almost 5 times higher than women in the majority population.[15] |
| **Maternal mental health** | 16% of pregnant women attending maternity services across Ireland are at probable risk of **depression during their pregnancy**.[16]<br>With the second highest birth rate in Europe, this means that each year over 11,000 women in Ireland could be experiencing, or at risk of depression during pregnancy. |
| **Violence against women** | 25% of Irish women had experienced **physical and/or sexual violence** since the age of fifteen.<br>8% of women in Ireland experience physical and/or sexual violence each year.[18] |
| **Dementia** | The incidence of **dementia** is substantially higher amongst women than men in Ireland (lifetime risk of one in six, compared with nearly one in 11 for men). |
| **Caring responsibilities** | Women undertake the majority of **unpaid care work** – 98% of those looking after the home/family were women in 2016.[19] |

11 Ipsos MRBI (2016) *Healthy Ireland Survey 2016- Summary of Findings*. Dublin: Department of Health.

12 Child Safety Europe (2014) What are European countries doing to prevent intentional injury to children?

13 Corcoran, Keeley, O'Sullivan, and Perry (2004) 'The incidence and repetition of attempted suicide in Ireland.' *European Journal of Public Health*

14 Griffin, E. et al. (2017) *National self-harm registry Ireland Annual Report 2016*. National Suicide Research Foundation.

15 All Ireland Traveller Health Study Team (AITHS) (2010) *All Ireland Traveller Health Study: Summary of Findings*. Dublin.

16 Findings of Well Before Birth Study. See TCD Press Release (November 2016) 'Rates of depression are high amongst pregnant women in Ireland'. O'Keane, V. (2016) Well before birth. REDEEM Research Group, TCD and National Obstetrics Services.

17 Fundamental Rights Agency (2014) *Violence Against Women: an EU-wide survey report.*

18 Alzheimer Society of Ireland, press release 'Women in their 60's twice as likely to develop Alzheimer's over the rest of their lives as they are breast cancer'.

19 Central Statistics Office (2017) *Women and Men in Ireland.*

The Health Research Board[20] found an equal proportion of women and men are admitted to psychiatric units and hospitals in Ireland. However, women are admitted in higher numbers for depressive disorders (67%) and eating disorders (89%). When looking at young people's mental health, girls are admitted to child and adolescent mental health in-patient units at a higher rate than boys, accounting for 60% of all under-18 psychiatric admissions.

There has been limited attention paid specifically to women's mental health in the national discourse. However, women's mental health has been recently illuminated by media reporting[21] showing that women in some of the poorest parts of Dublin are taking their own lives in the same numbers as men for the first time. The women are generally in their 20s and 30s, mothers of young children, who have often experienced poverty, early school leaving, homelessness and adverse childhood experiences. In 2018, we have also become increasingly aware of women affected by the national housing crisis. Women now make up 44% of the adult homeless population[22], which has been attributed to the rising numbers in family homelessness, the majority of which are lone parent, female-headed households.[23] An Irish study in 2015, *Homelessness, An Unhealthy State*[24], reported that almost 90% of women participants had a diagnosed mental or physical health problem. The negative impact of persistent homelessness on mental health is well documented.[25] The desperation of women finding themselves in tough life situations and not being able to access to mental health services was reflected in the experiences of some of the women we spoke to during this project.

20 Daly, A & Craig, S (2018) *Activities of Irish Psychiatric Units and Hospitals 2017 Main Findings*. Dublin :Health Research Board.

21 Kitty Holland, 21st May 2018 'Suicide on the rise among mothers in poorer Dublin areas'. *The Irish Times.*

22 2,547 homeless women, out of 5,834 homeless adults. The Department of Housing, Planning and Local Government (August 2018) Homelessness Data.

23 Mayock, P & Bretherton, J (2017) *Women's Homelessness in Europe*. Palgrave: MacMillan

24 O'Reilly *et al.* (2015) *Homelessness: An Unhealthy State.* Dublin: Partnership for Health Equity.

25 NWCI (2018) The impact of homelessness on women's health.

## Mental Health Services and Policy – Irish Context

How we have responded to women's mental health in Ireland has changed over time due to social and cultural changes. The 19th century saw the emergence of the asylum system, in which the so-called 'mentally ill' were admitted to large institutions often for the rest of their lives. This was a time of a powerful Church/State alliance in Ireland where a preoccupation with sexual morality became influential in the provision of healthcare. Women were more likely to be institutionalised, not just in psychiatric asylums, but also in mother and baby homes and Magdalene laundries. At its highest point in the 1950s, 1 in 100 per capita of the population was confined in institutions, a rate higher than anywhere else in Europe[26].

The 1960s saw a move away from large-scale institutions to small psychiatric units within general hospitals. Services followed the medical model of mental health, which focused on the treatment of mental illness locating 'the problem' within the individual in terms of pathology and ignoring a person's circumstances or experiences which may have led to illness. Continuing through the 1980's there was a continued focus on care in the community. But implementation was extremely slow and inconsistent and mental health services remained over-institutionalised.

By the early 2000's there was a move towards the social model to address mental health. The social model recognises that mental health is shaped by both individual experiences and factors such as relationships, community and culture. This reflects our growing understanding of the social determinants of health. In the past decade, there has been an increasing focus on mental *wellbeing*, rather than mental *ill-health*. There have been attempts to reduce the stigma surrounding mental health and to emphasise that mental wellbeing is an issue for everyone.

In 2006, the Government published our current mental health policy, *A Vision for Change*[27]. It placed a focus on the potential for recovery, committed to accelerating the shift from institutional to community care and emphasised the need for person-centred care. Implementation was impacted by the period of austerity, and 12 years since the policy was launched there are serious concerns about lack of treatment choices, over-use of medication and a lack of community-based alternatives to over-stretched hospital care. During the recession, rehabilitation and recovery services for long term mental health service users were cut and there were significant job losses in the mental health sector. In 2018, mental health services continue to be impacted by shortfalls in staffing, community care and in-patients beds.[28]

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26 Brennan, D. (2007) 'A sociology of institutionalisation of the 'mentally ill' in Ireland', Department of Sociology, Trinity College Dublin.

27 Government of Ireland (2006) *A Vision for Change – report of the expert group on mental health policy.* Dublin: The Stationery Office.

28 Examples of media reports – *The Irish Times* (28.02.18) 'Patients who are at a low point are left languishing on chairs in a chaotic ward - Psychiatric nurses take action over crisis in services' and *The Irish Times* (09/09/2018) 'Nearly 2,700 young people waiting for mental health appointments'

Over the past decade, mental health in Ireland has been impacted by underfunding and understaffing. There have been reports of children admitted to adult inpatient mental health units. Male suicide has been consistently high, particularly amongst ethnic groups such as Travellers where the male suicide rate is 7 times higher than men in the majority population. People seeking support often have to appear as crisis admissions through Emergency Departments, while others face long waits for mental health services in the community. As we heard in our conversations, women seeking mental health supports in Ireland today are acutely aware of the underdevelopment of community supports. They also know that the public narrative emphasises children's and men's mental health.

Ireland has what is often described as a two-tier health service. That is, there is different access depending on whether you are a public or a private patient. The two-tier system means that women without private health insurance, generally poorer women, have unequal access to mental health supports when they need it. It is hoped that Ireland's mental health infrastructure is on the cusp of significant change. The 2017 *Sláintecare*[29] cross-party plan for universal healthcare in Ireland highlighted the under-resourcing of community mental health services and reliance on medication over psychological and counselling services. If implemented, Sláintecare will develop single-tier access to healthcare services, based on need not ability to pay. A greater proportion of the Health Budget would be spent on mental health services, with significant investment in the community supports and therapeutic interventions sought by women.

Following the Referendum to remove the 8th amendment from the Constitution and provide abortion care, Ireland has entered a new phase in the drive for women's equality. This drive is particularly focused on women's health needs, including the commitment of the Department of Health and the HSE to develop a women's health action plan with NWCI[30], to lead developments for women's mental and physical health.

29 Oireachtas Committee on the Future of Healthcare (May 2017) *Sláintecare report*. Dublin: Houses of the Oireachtas.

30 Action 2.1, Government of Ireland (2017) *National Strategy for Women and Girls 2017-2020.*

# Methodology

## Background to the Project

In 2017/8 NWCI undertook a programme of conversations with groups of women across the country in which women told us about their experiences of mental health and what supports their wellbeing. The intention was to gather women's experiences in their own words. In our conversations, NWCI recognised all women participants as the experts in their experience of mental health and wellbeing.

## Aims and Objectives

The aim of the conversations was to document women's varied experiences of mental health and well-being.

The objectives were:

— To listen to women's own experiences of mental health and well-being

— To learn about the main issues for women in achieving good mental health and how services can be more woman-centred

— To inform NWCI's work to promote women's mental health and the development of women-centred mental health services

## Participants and Recruitment Process

NWCI sourced six groups of women from our national membership base. Across the six conversations, there were 76 women in total, with an average of 10-15 women in each group. All participants were over-18. In addition to these 6 conversations, an NWCI group member, Cairde: Ethnic Minority Health Service, allowed us to include data from their own focus group research on mental health in Ireland[31]. This included four separate focus groups with women from African, Roma, Muslim, and Eastern European backgrounds.

Women's voices have been largely absent from discussions about mental health in Ireland and even more so for migrant, minority ethnic, disabled and deaf women. Our conversations aim to be a starting point in opening the discussion about women's mental health in Ireland. To recruit participants, we contacted group members of NWCI with a particular interest in women's mental health. Conducting conversations with women in member groups enabled shared trust and understanding between the participants in each conversation.

Women are not a homogeneous group and have varying mental health needs, depending on their different lives, circumstances and experiences. Our conversation groups were selected in an attempt to provide an overview of women's mental health in Ireland. Each woman that came to our conversations brought her own individual experiences and identities. The women participants combined a diversity of ages and

31 Cairde (2015) *Ethnic Minorities and Mental Health in Ireland: Barriers and Recommendations*.

backgrounds. We met with a Traveller women's group, a rural women's group, a third level student group and three community women's groups. Participants represented a range of women, including: older, younger, rural, urban, Traveller, Roma, migrant, mothers, single women and working women. Three of the conversation groups were based outside of Dublin. We are aware that a pioneering project such as this will not be representative of all women and we recommend further research to capture a larger sample of women in all their diversity (see 'Need for Further Research' below).

As our conversations were designed to provide a broad overview of women's mental health in Ireland, we did not specifically invite groups of women who have long-term, enduring mental ill health. However, a significant minority of women who participated had experienced mental health difficulties and engagement with mental health services. Further study is required on the needs of women with experiences of mental illness (see 'Need for Further Research' below).

## Research Design and Data Collection

### Theoretical Underpinning

In advance of the project we examined theories of mental health, considering the wide variety of understandings and definitions. For the purpose of the conversations, we adopted the World Health Organisation (WHO) definition of health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease'[32].

In undertaking the conversations and during analysis we worked within a feminist framework[33], where gender and power are considered as underlying factors in understanding women's mental health and the way that society responds to it. Using an intersectional approach to feminist research[34], our report examines women's mental health at different intersections of identity, social positions, policies and social structures. While carrying out this project, we felt it was important to be reflexive, acknowledging that as women and as researchers we hold our own opinions and ideas on the issues of gender and mental health.[35]

### Research Design

The conversations were designed to ensure the maximum participation of women in each group, to foreground their voices and experiences, rather than the researchers' expectations or presumptions. To do this, we used qualitative data collection methods, in the form of semi-structured conversation groups. Our conversations were developed as open focus groups, responsive to the needs of each particular group. This placed an emphasis on the subjective experiences of the women participants and it allowed for flexibility and fluidity within discussions. Open-ended questions served as a guide, but also allowed participants the freedom to concentrate on the issues that were important to them.[36] Conversation focused on

32 WHO (2001) *World Health Report: Mental Health, New Understanding, New Hope.*

33 Byrne, A., Lentin, R. (Eds). (2000) *(Re)searching Women: Feminist Research Methodologies in the Social Sciences in Ireland.* Dublin: Institute of Public Administration.

34 Bauer, G (2014) 'Incorporating Intersectionality Theory into Population Health Research Methodology: Challenges and the Potential to Advance Health Equity', *Social Science and Medicine*, (110) 10-17.

35 Patnaik, E (2013) 'Reflexivity: Situating the Researcher in Qualitative Research', *Humanities and Social Science Studies* (2)(2) 98-106

36 Miller, R & Brewer, J (2003) *The A-Z of Social Research.* London: SAGE.

women's experiences of mental health and wellbeing, access to services provision, as well as the quality of services they may have received.

## Mental Health Conversation Process

The programme for each conversation lasted two hours. This included some ice-breaker exercises, viewing the 'Out of Silence' film and group discussion.

NWCI's film 'Out of Silence – Women's Mental Health in Ireland'[37] was used to frame the conversations. The film, produced for the NWCI co-hosted World Congress on Women's Mental Health 2017, combines women speaking about their personal experiences and expert interviews across five areas: the impacts of domestic violence; young women and eating disorders; older women and the impacts of dementia; migrant women's mental health; and perinatal mental health. We asked participants to discuss the issues that arose in the film, to highlight issues that were missing, to consider the relationship between gender and mental health and, finally, to provide suggestions for change. The film was a useful tool to open discussion, enabling participants to consider the issues that affect women specifically and to discuss a sensitive issue.

Over the course of the six conversations, there were minor changes to the programme to suit the needs of particular groups or to take on board suggestions from previous groups. For example, for the first three conversation groups, we began each session with the full 20-minute film. However, due to feedback from participants, we amended the programme to spend more time on warm-up activities on mental health and gender before showing edited clips.

At the end of each group session, women were given a short questionnaire, asking them about the usefulness of the discussion. All completed questionnaires either 'agreed' or 'strongly agreed' that the conversation was interesting and helpful. The questionnaire also left a space for additional comments to enable each woman to highlight any issues she may not have been comfortable discussing within the group.

## Data Analysis

Each conversation was manually recorded and transcribed by one of the researchers, ensuring that all identifiable information was removed. We also received data from four focus groups transcribed by a Cairde staff member. All data was analysed using thematic analysis, a method used to identify and report patterns or themes.

Individual conversation transcripts were read numerous times by two researchers and open codes identified and categorised into general themes. These open codes were then examined to identify relationships and connections. Looking across and within each conversation group, dominant themes emerged across all groups, as well as themes which were specific to particular conversation groups. The two researchers discussed, reviewed and critiqued the emerging themes together. Ultimately, through a process of refinement, the themes were divided into two key areas; *Women's Experiences*: issues impacting women's mental health, and *Women's Call for Change.* A draft report of the key findings was sent to all participating groups for their comments, perspectives and confirmation of the findings.

37 NWCI's 'Out of Silence – women's mental health in Ireland' film.

## Key Themes Identified

| Key Themes | Sub-Themes |
|---|---|
| **Women's Experiences** | |
| **Women's experiences of mental health** | Stigma, Isolation, Self-Harm, Suicide, Anxiety, Depression |
| **Expectations of womanhood** | Pregnancy, Motherhood, Caring Responsibilities, Expectations of Womanhood |
| **Social determinants of women's mental health** | Violence Against Women, Social Conditions, Addiction, Abuse, Class, Trauma, Financial Stress |
| **Women's mental health at different life stages** | Young women, Body Image, Ageing, Dementia, Menopause |
| **The diverse experiences of women and their mental health** | Intersectionality, Religion, Culture, Language, Immigration, Traveller Identity, Discrimination |
| **Women's Call for Change** | |
| **Prevention** | Education, Early Intervention, Representation and Inclusion |
| **Training** | Gender Equality Training, Trauma Informed Care, Training on Culturally Appropriate Service Provision |
| **Adequate supports** | Alternatives to Medication, Counselling, Being Heard by Professionals, Women's Spaces, Peer Support, Addressing Social Determinants, Culturally Appropriate Services |
| **Access to mental health services** | Improvements in Services, Waiting Lists, Access to Services, Funding |

## Ethical Considerations

NWCI is aware of the sensitivity of our subject matter and we were conscious of the need for a safe space for women to have conversations about mental health.

We ensured that all interested member groups received information regarding the aims and objectives of the project, confidentiality, the conversation process and how the data would be used. We also prepared posters for each organisation to share with potential participants, providing similar information in condensed form. The direct contact person from each organisation obtained consent from their group to participate. Following a recommendation from our second focus group, we also asked the direct contact person to review the film to check for suitability prior to each conversation.

At the beginning of each conversation, we explained the topics that would be covered in the film, the purpose of the session and we provided information on available mental health supports. Our direct contact person from each organisation sat in on the session and was the support person on the day. It was acknowledged that mental health can be a difficult subject matter and if anyone needed time out of the session that they were free to do so at any point. Participants were also verbally assured that their confidentiality was strictly protected at all stages.

At the end of the research process, each group was sent a draft of the findings. This ensured that participants could provide feedback if they felt their words/ideas were not represented accurately.

## Limitations

This was an exploratory project, including the perspectives of more than 100 women living in Ireland. While we sought to include a broad range of life experiences, we are aware that this research does not represent all women in their diversity. Due to time and resource constraints we were unable to undertake individual conversations with all of the communities / identities that we would have liked to involve, for example, LGBTQI women and women with disabilities. Below we highlight the need for further research to build on the perspectives captured here.

## Need for Further Research

This exploratory project contributes to the evidence base of women's mental health in Ireland. Women's voices have been largely absent or ignored on the issue of mental health and our conversations aim to be a starting point for further research. As our conversations were designed to provide a broad overview of women's mental health in Ireland, we did not specifically invite groups of women who have long-term, enduring mental ill health. However, a significant minority of women who participated had experienced mental health difficulties and engagement with mental health services.

While we aimed to engage with a broad range of women we recognise that this report does not represent all women in their diversity. Developing our understanding of different women's needs is important. For example, the LGBTIreland report[38] documented significant mental health needs within the LGBTI community. Intersections also exist between disability and mental health[39]. The emotional challenges involved in living within a disabling environment and an ablest society can contribute to experiences of mental distress for women with disabilities at various moments in their lives.

To build on this project NWCI recommends further research be conducted to:

— Develop a research programme to examine the needs of women experiencing significant mental health difficulties.

— Examine the treatment of and the care pathways for mental health conditions prevalent amongst women.

— Conduct wider research to capture a larger sample of women in all their diversity.

— Research woman-centred mental health policies and services, with particular focus on: primary care interventions; trauma-informed care; and women's caring responsibilities.

38 HSE, Glen, BeLongTo, TCD (2016) *The LGBTIreland* Dublin: GLEN and BeLonG To.

39 Smith, J (2015) *Women, Disability and Mental Distress.* Surrey: Ashgate

# Out of Silence: Women's Experiences

## Women's Experiences of Mental Health

Within the conversations, women provided an insight into their personal experiences of mental health. Research shows that gender differences exist not only in relation to the kinds of mental health problems experienced by women and men, but also in their patterns of help seeking and treatment.[40]

### Mental Health Diagnoses

Women's experiences of anxiety and depression were a recurring theme in the conversation groups. Women are affected by depression at twice the rate of men, and women are more likely to experience anxiety.[41] Participants felt that a large percentage of women were experiencing depression, anxiety and panic attacks.

***"Women are suffering anxiety in very high rates – see the amount of women with panic attacks. I think it comes from being everything to everyone"*** (woman participant, women's community group 1)

Women also felt their symptoms were often dismissed, not taken seriously, or mistreated. These experiences reflect research[42] which shows that women and men seek and receive treatment for mental health difficulties in different ways - women are less likely to receive specialist care and twice as likely to be prescribed psychotropic drugs. Women believed that there was an over-reliance on prescribing medication and lack of access to counselling and talking therapies.

***"My mam would suffer from depression and instead of talking to her and giving her help, they just kept giving her tablets"*** (woman participant, women's community group 2)

One participant also highlighted the issue of Borderline Personality Disorder (BPD). This diagnosis predominantly impacts women, with a 3:1 female to male ratio.[43] In her experience, women with this disorder are often ignored and links between personality disorders and past trauma are not investigated. 80% of people with a diagnosis of BPD have a history of trauma.[44]

***"Illnesses such as borderline personality disorder impact women more and are dismissed, not treated...it is hugely linked to trauma, which no one wants to talk about"*** (woman participant, third level student group)

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40 Women's Health Council (2002) 'Submission to the European Commission's Green Paper: Improving the Mental Health of the Population'. See also World Health Organisation (2001) 'WHO Gender Disparities in Mental Health'.

41 Women's Health Council (2004) *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision.* Dublin: Department of Health

42 Women's Health Council (2004*) Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision.* Dublin: Department of Health.

43 Skodol, A. and Bender, D. (2003) 'Why are women diagnosed borderline more than men?', *The Psychiatric quarterly*, 74(4):349-60.

44 Herman J, Perry J, van der Kolk B (1989) 'Childhood trauma in borderline personality disorder', *American Journal of Psychiatry*, 146(4):490-5

## Stigma and Isolation

Women in the conversations discussed the silence and shame that can surround mental health. As highlighted previously, women face additional stigma when they fear that their caring/parenting abilities may be judged.

***"Embarrassment and shame is a key reason why we* [women] *don't tell people how we feel"*** (woman participant, women's community group 1)

Some of the migrant women's groups shared by Cairde particularly highlighted the issue of stigma. The African women's group discussed the association between mental health issues, madness and witch craft. The Muslim women's group felt that mental health issues can be viewed as a sign of weakness, and they would be labelled as ***'crazy'***.

***"Like, if our people know that I am suffering from mental health or something like that, they might stay away from me, or look down on the family and put a stigma on me"*** (woman participant, Cairde African women's group)

Migrant women felt that issues such as language barriers and living away from family support networks led to feelings of isolation. This reflects the findings in Cairde's *Ethnic Minorities and Mental Health in Ireland* report[45] that shame, together with isolation and exclusion, were the most challenging barriers ethnic minority communities face when dealing with mental health issues in Ireland.

***"I would say isolation. Often times you have women who are foreign to Ireland, does not speak the language and is living far from the centre, they would be lonely, and wouldn't obviously have family members here so I think isolation would cause different types of problems and demotivate them to seek help"*** (woman participant, Cairde Muslim women's group)

45 Cairde (2015) *Ethnic Minorities and Mental Health in Ireland Report: Barriers and Recommendations.*

Women highlighted the impact loneliness and isolation can have on their mental health. The rural women and migrant women's groups appeared to be particularly impacted by this issue. Loneliness has been associated with a number of mental health conditions, including anxiety, depression and a more critical view of self. It has also been linked with cognitive decline and dementia in older people.[46] Older women participants talked about living alone, loss of a partner or marital breakdown, lack of community and lack of rural transport as issues that compound their loneliness and isolation.

***"I live on my own and it can be very lonely. Sometimes you can feel like you're going a bit mad...it can be hard to make friends, especially in a rural area"*** (woman participant, rural women's group)

## Self-Harm and Suicide

Self-harm and suicide were raised a number of times in the conversations. Women felt self-harm was a significant problem, particularly for young girls. They also highlighted that women's suicide attempts were not taken seriously and very little follow up supports were on offer. An Irish study[47] has shown the incidence of attempted suicide was higher among women. In 2016, the female rate of self-harm was 24% higher than the male rate. The highest rates of self-harm were amongst young women (15-19 year olds) - one in every 131 girls in this age group presented to hospital as a consequence of self-harm.[48]

***"Women are seen as crying wolf, their suicide attempts are dismissed"*** (woman participant, third level student group)

Traveller women highlighted the alarming rates of suicide in their own community – 5 times higher than settled women[49]. They emphasised the need for respectful, accessible and culturally appropriate services, particularly for young Traveller women.

***"Usually we [society] don't give young girls their voice on mental health...you can wake up other people to the importance of keeping an eye on people with these experiences"*** (woman participant, Traveller women's group)

46 Harvey, B. and Walsh, K. (2016) *Loneliness and Ageing, Ireland, North and South.* Institute of Public Health.

47 Corcoran, P., Keeley, H., O'Sullivan, M. and Perry, I. (2004) 'The incidence and repetition of attempted suicide in Ireland', *European Journal of Public Health,* 14(1): 19-23.

48 Griffin, E., Dillon, C., Arensman, E., Corcoran, P., Williamson, E. and Perry, I. (2017) *National self-harm registry Ireland Annual Report 2016.* National Suicide Research Foundation

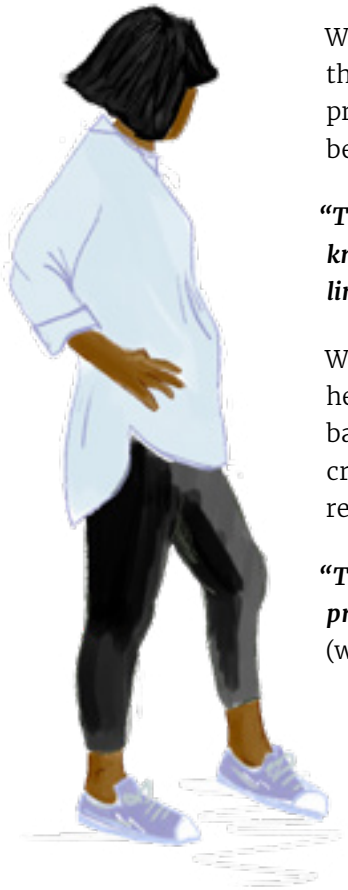
49 All Ireland Traveller Health Study Team (AITHS) (2010) *All Ireland Traveller Health Study: Summary of Findings.*

## Expectations of Womanhood

Women in the conversation groups identified that gender inequalities and the social roles ascribed to women have a profound impact on their mental health and wellbeing. In particular, they highlighted pregnancy, motherhood, caring responsibilities and societal expectations placed on women as key issues impacting their mental health.

### Pregnancy

Research[50] has found 16% of pregnant women in Ireland are at risk of perinatal depression, a figure higher than the European average. Poor social supports, socio-economic status, experiences of violence and race/ethnicity are contributing risk factors to developing perinatal depression.[51] Women have limited access to perinatal psychiatry and mother-and-baby units. In 2017, there were only three perinatal psychiatrists based in the Dublin maternity hospitals on a part-time basis[52]. The *National Maternity Strategy 2016-26* and the HSE's 2017 *Model of Care for Perinatal Mental Health* commit to addressing these deficits.



Women participants related to the experience of perinatal depression shared in the 'Out of Silence' film. Within the conversation groups, women talked about the prevailing perception that women are content during pregnancy and how this can be a barrier to seeking support.

***"The expectation is in pregnancy you are happy. There's no knowledge of perinatal depression. No-one talks about it, I think it's linked to shame"*** (woman participant, third level student group)

Women identified lack of knowledge about perinatal mental health and the absence of a screening process as significant barriers to getting support. These barriers led to women being at crisis point before any intervention was available. This feedback reflects the findings of a number of Irish studies.[53]

***"There isn't realisation around the experience of depression during pregnancy. It would be a great idea to be scanned for everything"*** (woman participant, women's community group 1)

50 O'Keane, V. (2016) *Well Before Birth*. REDEEM Research Group, TCD and National Obstetrics Services.

51 Lancaster, C.A. *et al*, (2010) 'Risk factors for depressive symptoms during pregnancy: a systematic review', *American Journal of Obstetrics and Gynecology,* 202(1), 5– 14; O'Keane, V. & Marsh, M.S (2007) 'Depression during pregnancy', *British Medical Journal*, 334, 1003–1005.

52 HSE Mental Health Service (2017) *Specialist Perinatal Mental Health Services. Model of Care for Ireland.*

53 For example, Farrelly, M. and Nagle, U. (2017) *Women's views and experiences of having their mental health needs considered in the perinatal period.* Dublin: DCU & Rotunda; Higgins, A. *et al.* (2017) *Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland.* Dublin: HSE.

## Motherhood and Caring Responsibilities

Women's roles as mothers and carers were discussed in all the conversations. These roles were described as a positive aspect of women's lives; however, ***"always putting family needs first"***[54] can also have a detrimental impact on women's mental health.

***"I have four children and I gave up work to care for them, I often have a feeling of being invisible"*** (woman participant, women's community group 3)

Women undertake the majority of unpaid care work in Ireland. In 2016, 98% of those looking after the home/family were women.[55] Caring responsibilities can have a negative impact on mental and physical health, leading to exhaustion, depression, injury and greater vulnerability to illness. This was reflected in the conversations, where women described the ***"overwhelming sense of responsibility"***[56] that comes with caring duties. The World Health Organisation[57] has referred to the pressure that women face as the triple burden of productive, reproductive, and caring work. An improvement in women's position in society, alongside a fairer distribution of care responsibilities would go a long way to reducing women's risk of experiencing mental illness.[58]

***"This intense childcare causes that they fall into the tunnel of isolation, fatigue, and low self-esteem"*** (woman participant, Cairde Eastern European women's group)

Women's roles as carer and mother also impacted on their ability to seek mental health supports. Women felt that they could not take the time out to concentrate on their own mental health due to their caring responsibilities.

***"Mothers are picking up the slack for inadequate services, we need to care for carers"*** (woman participant, third level student group)

Women were also less inclined to seek help from services due to fear of being judged by professionals as unfit mothers/carers. This reflects the findings of the Mind Mothers study[59], which identified women's caring role as a potential barrier for both women and health professionals - fear of social work referrals were barriers for women disclosing mental health issues and fears that women would misinterpret questions as a judgement of their mothering capacity was a barrier to professionals offering adequate support.

***"There is a stigma for women with depression. Do you want social workers banging on the door if you say you are depressed? As a result, women can be cagey about where they will go for help"*** (woman participant, women's community group 2)

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54 Woman participant, women's community group 1

55 Central Statistics Office (2017) *Women and Men in Ireland 2016.*

56 Woman participant, women's community group 1

57 WHO (1999) *Women and Occupational Health. Issues and policy paper prepared for the Global Commission on Women's Health.*

58 Women's Health Council (2004) *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision.* Dublin: Department of Health

59 Higgins, A. *et al.* (2017) *Mind Mothers Study Report: Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland.* Dublin: HSE.

## Social Determinants of Women's Mental Health

According to the World Health Organisation (2014)[60]:

*'A person's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk.'*

Many risk factors for mental health difficulties are experienced more frequently by women. Women are more likely to be in lower paid employment, to have caring responsibilities, experience discrimination, to parent alone and to experience domestic and sexual violence.

### Violence Against Women

In 2014, the EU Fundamental Rights Agency[61] reported that 25% of Irish women had experienced a form of physical and/or sexual violence since the age of fifteen and 8% experience physical and/or sexual violence each year. Women experiencing domestic violence are several times more likely to self-harm, be suicidal, and misuse drugs or alcohol.[62] Women in conversations discussed the impacts of violence and abuse on their mental health, describing being ***"chipped away at"***, ***"gas-lighted"***[63], and ***"controlled"***[64]. Trauma resulting from violence can have long lasting, devastating effects on women.

***"I got away from him, I told my mum and she said you're never going back. That was 20 years ago, still something I see or hear can bring me right back to the fear"*** (woman participant, women's community group 1)

Women felt that there was a stigma attached to experiencing domestic and sexual violence. They felt that women were too embarrassed to tell people for fear of being judged and sometimes self-blame could lead to mental health issues. This echoes Women's Aid's findings[65] that many women who have experienced abuse have been isolated from their family and social supports, and humiliated into self-shame, self-blame and secrecy.

***"She*** **[woman in 'Out of Silence' film]** ***has a black eye but there is a lot more behind it. She's blaming herself, it all builds up in your brain and you get depressed"*** (woman participant, Traveller women's group)

60 WHO (2014) *Social Determinants of Mental Health.*

61 Fundamental Rights Agency (2014) *Violence Against Women: an EU-wide survey report.*

62 Mental Health Europe (2012) *Shaping attitudes. A handbook on domestic violence and mental health.* Brussels.

63 'Gaslighting' is a form of psychological abuse where the perpetrator manipulates their partner into doubting themselves, their memories and judgement, or even their sanity, having a devastating impact on their mental health and wellbeing.

64 Woman participant, women's community group 1.

65 Women's Aid (2015) *Impact Report.*

Women also felt that mental health services did not consider how experiences of violence and abuse can impact on their mental health. This sometimes led to misdiagnosis or re-traumatisation within services. Research[66] has highlighted that violence against women is a public mental health problem and mental health professionals need to identify, prevent and respond to it more effectively. Poor identification of violence experienced by women can lead to non-engagement with services and poor mental health outcomes for women.

***"There is nothing within the health service to explain the experience of abuse when you are getting treatments. There is nowhere you can mark down what has happened to you"*** (woman participant, women's community group 1)

Trauma-informed care proposes that mental health services should accommodate the vulnerabilities of trauma survivors and understand their symptoms in the context of their experiences.[67]

Migrant women face additional barriers to seeking help when experiencing domestic violence as many are dependent on their spouse for their residency permit. When the relationship ends so too does the dependent spouse's leave to remain in the country. Migrant women experiencing domestic violence may therefore be faced with the 'choice' of having to leave the country or stay in an abusive relationship. For many women, returning to their country of origin is not a viable option, for economic, social, safety or cultural reasons.[68]

***"I think there has been issues in the past when women were reluctant to go out and seek help because they feared that this will affect their stay which is dependent on spousal visa"*** (woman participant, Cairde Muslim women's group)

66 Oram, S., Khalifeh, H., and Howard, L. (2017) 'Violence against women and mental health', *Lancet Psychiatry* 4: 159-70; Howard, L., Trevillion, K., Agnes-Davies, R. (2010) 'Domestic violence and mental health', *International Review of Psychiatry* 22(5): 525-34

67 Fallot, R. and Harris, M. (2018). *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol Community Connections*, Washington, D.C.

68 Women's Aid (2016) *'Take Action to Make Women and Children Safe from Domestic Violence.'*

## Class/Socio-Economic Disadvantage

Women in the conversations discussed how racism, poverty and social disadvantage have a huge impact on their mental health. Living in poverty or being faced with discrimination or exclusion is a stressful experience and women in these circumstances tend to experience poorer mental health.[69]

***"The poor income that women have to survive on, you have to be fed and sleep in comfort before your health comes in"*** (woman participant, Traveller women's group)

As well as having an impact on women's mental health, socio-economic status also determines the level and quality of supports and services a woman receives. Women discussed the high cost of services such as counselling and group supports and they criticised unacceptable waiting lists for public mental health services. Ireland's two-tier model of healthcare is based on a patient's ability to pay rather than on their health needs.[70]

***"There isn't access for a person who doesn't have health insurance. You're waiting and waiting on a list for public services"*** (woman participant, women's community group 2)

The Traveller women's group particularly highlighted the need to address the intersectional dimensions of women's mental health, as Traveller women are ***"doubly-discriminated"***.[71] Roma women from Cairde reiterated the need to attend to the social determinants of women's mental health.

The key social determinants impacting Traveller and Roma women's health include individual and institutional racism. Traveller and Roma women continue to be among the most marginalised groups in Ireland. Census 2016[72] found that 13% of Traveller females were educated to upper secondary level or above, compared with almost 69% of the general population. A National Needs Assessment of Roma in Ireland[73] found that approximately 10% of Roma respondents are living in extreme poverty, in sub-standard accommodation. This inevitably has an impact on mental health, with 60% of Roma women reporting frequent mental distress (more than 14 days of the previous month when their mental health was not good).

***"My biggest stress is financially, as I am a single mother of 7 and I am claiming social welfare. I fear that one day my payment will stop, and I have no other income"*** (woman participant, Cairde Roma women's group)

69 Farrell, C., McAvoy, H., Wilde, J. and Combat Poverty Agency (2008) *Tackling Health Inequalities. An All-Ireland Approach to Social Determinants*. Institute of Public Health

70 Oireachtas Committee on the Future of Healthcare (2017) *Sláintecare Report*.

71 Woman participant, Traveller women's group. Analysisyt

72 Census 2016. Central Statistics Office.

73 Pavee Point Traveller and Roma Centre & Department of Justice and Equality (2018) *Roma in Ireland – A National Needs Assessment*.

## Women's Mental Health at Different Life Stages

Generally, women have different mental health needs at different periods of their lives. Eating disorders are more prevalent among younger women; during child-bearing years women may require mental health supports related to pregnancy; older women, partly due to longevity, are more likely to develop dementia.

### Young Women

Women in the conversations identified body image, social media and self-harm as key areas of concern for young women's mental health. Approximately, one third of adolescent females in Ireland diet regularly and are dissatisfied with their body, with around 10% being at risk of eating disorders[74]. Women felt that social media affected women's body image.

***"Body image is a huge problem; social media has a huge impact on your mental health... your life online isn't the life you're living. Social media can be so empowering but can also destroy you"*** (woman participant, third level student group).

Participants also felt that mental health services for young women were inadequate. Women named inconsistencies in the care provided by Child and Adolescent Mental Health services, as well as the difficult transition for young women from adolescent to adult services when they turn eighteen.

***"There should be drop in appointments and services for young girls but there's nothing really"*** (woman participant, women's community group 2)

74 HSE (2018) 'Eating Disorder Services. HSE Model of Care for Ireland'.

## Older Women

Some of the older women acknowledged that there have been some positive developments in the area of mental health in their lifetime. They felt that there are more supports available and people are more open talking about their mental health.

***"As an older woman, years ago women couldn't get support from their doctor, they would look to their family instead. 20 years ago, we would not be having this conversation"*** (woman participant, women's community group 3)

Women identified menopause, society's attitude to ageing, loneliness, and dementia as key issues affecting older women's mental health.

They felt that menopause was a taboo subject and that they were not made aware of the mental health implications. Analysis carried out by the Women's Health Council[75] found that up to 30 per cent of depressive episodes in women start as a result of a reproductive event, such as pregnancy, childbirth, infertility, or menopause. Women wanted more information and supports to be made available.

***"Menopause has a very big impact on mental health. Oh my God, the shock of it. You're told about the sweats but not told about the anxiety"*** (woman participant, women's community group 1)

Participants discussed the impacts that dementia can have on a family and how the gendered element of dementia is not widely known. Two-thirds of the population with dementia are women[76], however, participants described the lack of awareness/attention to this issue.

***"The amount of women getting Alzheimer's, more than men. But it's not getting talked about, or getting attention"*** (woman participant, Traveller women's group)

The high rate of female dementia was a cause of fear for individual women themselves, but was also referred to in relation to the consequent family caring responsibilities which women are required to take on in middle-age.

***"I am in my 50s and responsible for three ageing parents, mine and my husband's. We need to think about the consequences of dementia for people in middle age who are providing care"*** (woman participant, rural women's group)

75 Women's Health Council (2004) *Women's Mental Health. Promoting a Gendered Approach to Policy and Service Provision.*

76 Pierce, M. et al. (2014) *Prevalence and Projections of Dementia in Ireland, 2011- 2046.* TCD and NUIG.

## The Diverse Experiences of Women

Research[77] shows that marginalised women (including asylum seekers, homeless women, Traveller and Roma women, LGBTQI women, deaf women and women with disabilities) are disproportionately impacted by poor mental health. Gender inequality means that all women are subjected to regular micro-aggressions[78] which over time can take its toll on their wellbeing. For women with multiple, intersecting structural oppressions this discrimination is often compounded.[79]

***"You have to address the social determinants, you aren't just discriminated as a woman, we are doubly-discriminated"*** (woman participant, Traveller women's group)

The Traveller women's conversation advocated that health services needed to change in order to meet Traveller women's and their community's needs. They felt that issues such as racism, discrimination, access to health information and a lack of cultural awareness impacted on their experiences of mental health services. 67% of service providers agreed that discrimination against Travellers sometimes occurs in their use of health services, resulting in substandard treatment.[80]

***"Who's the first person you meet there [in doctor's surgery]? If the man is not nice to you, you walk out and that experience spreads among all the neighbours. It doesn't cost much to make people welcome"*** (woman participant, Traveller women's group)

Cairde's migrant women's groups had some common themes throughout their discussions – feelings of isolation, stigma and not being listened to by health professionals. They also highlighted the need for peer support within their own communities and access to mental health service providers who speak their language and/or understand their culture. This reflects the intercultural approaches to health identified in the HSE's *Intercultural Health Strategy*[81] - language and communication, culturally appropriate services, and working in partnership with ethnic minorities.

***"Is there somewhere that people could go like counsellors, African counsellors, that can identify with our own people, that have the same mentality?"*** (woman participant, Cairde African women's group)

The experiences of women asylum seekers living in Direct Provision accommodation was also named in our conversations as a serious mental health concern. This echoes a recent study[82] in Limerick where women living in Direct Provision found that the lengthy asylum process in Ireland had detrimental health implications for women. Women's mental health was affected by their inability to

77 For example see: Department of Justice (2017) *National Traveller and Roma Inclusion Strategy 2017-21;* HSE, Glen, BeLong To, TCD (2016) *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*; Mental Health Reform & Simon (2017) *Homelessness and Mental Health: Voices of Experience.*

78 'Microaggressions' are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.

79 Imkaan, Positively UK and Rape Crisis England and Wales (2014) *'I am More than One Thing': A guiding paper by Imkaan, Positively UK and Rape Crisis England and Wales on women and mental health.*

80 All Ireland Traveller Health Study Team (AITHS) (2010) *All Ireland Traveller Health Study: Summary of Findings.*

81 HSE (2007) *National Intercultural Health Strategy 2007-12.*

82 Doras Luimni (2012) *Migrant Women's Awareness, Experiences and Perceptions of Health Services in Limerick.*

engage in employment, income poverty, exclusion from society, caring for children in shared accommodation and lack of privacy.

***"There should be counsellors going in to speak to women about their experiences before they even come to Direct Provision. They should be able to make their own food for their families, and provide for their families, it's a basic human right"*** (woman participant, rural women's group)

The issue of LGBTQI mental health was raised within two of our conversations. The Traveller women's group and the third level student group both talked about gender identity and the impacts on mental health, particularly highlighting transgender women's needs. Transgender women face high levels of stigmatisation and discrimination that negatively impact their lives. Issues such as isolation, family rejection and marginalisation at home, in schools and in the workplace can lead to poor mental health outcomes such as stress, anxiety, depression and suicidality. In TENI's 'Speaking from the Margins' survey[83] on trans mental health in Ireland, almost 80% of participants had considered suicide and half of those had made at least one attempt.

***"LGBT mental health and trans health issues are huge"*** (woman participant, third level student group)

83 McNeil, J., Bailey, L., Ellis, S. and Regan, M. (2013) *Speaking from the Margins. Trans Mental Health and Well Being in Ireland.* Transgender Equality Network Ireland (TENI).

# Out of Silence: Women's Call for Change

As the women participants spoke about their experiences of mental health and wellbeing, they began to identify areas which they felt should be prioritised to support women's wellbeing. In so doing, they made 'calls for change' in four areas – prevention, training, adequate supports; and access to mental health services – which they felt could support women's wellbeing and improve mental health services for women in Ireland.

These priorities for change come directly from the women who participated in our conversations. They represent a distillation of their wisdom and experience both in their own wellbeing and in engaging with services. In some cases, their priorities may reflect work which is already underway in parts of the country and which can be extended nationwide. Other priorities point to the need to build new supports for women which do not currently exist.

## Prevention

Women felt that mental health issues had to get to crisis point before any intervention was available. Our conversation participants recommended more investment in the prevention of mental ill health.

***"Every person from all socio-economic backgrounds should be educated as much as possible to change attitudes, eliminate stigma and promote happiness"*** (woman participant, women's community group 2)

Women felt one vital aspect of prevention was education, and that mental health and wellbeing should be taught to all children in school. They felt if the subject was discussed openly with children from an early age, it would reduce stigma and teach young people vital coping skills. Following their annual 'mental health attitudes survey'[84] (where 61% believed being treated for a mental health difficulty was seen as a personal failure), St Patrick's Mental Health Services has called for a national mental health awareness-raising and anti-stigma programme for children and young people.

***"Training and education for children to recognise mental health signs…from day one for children to realise that it isn't weakness to talk about your feelings"*** (woman participant, women's community group 3)

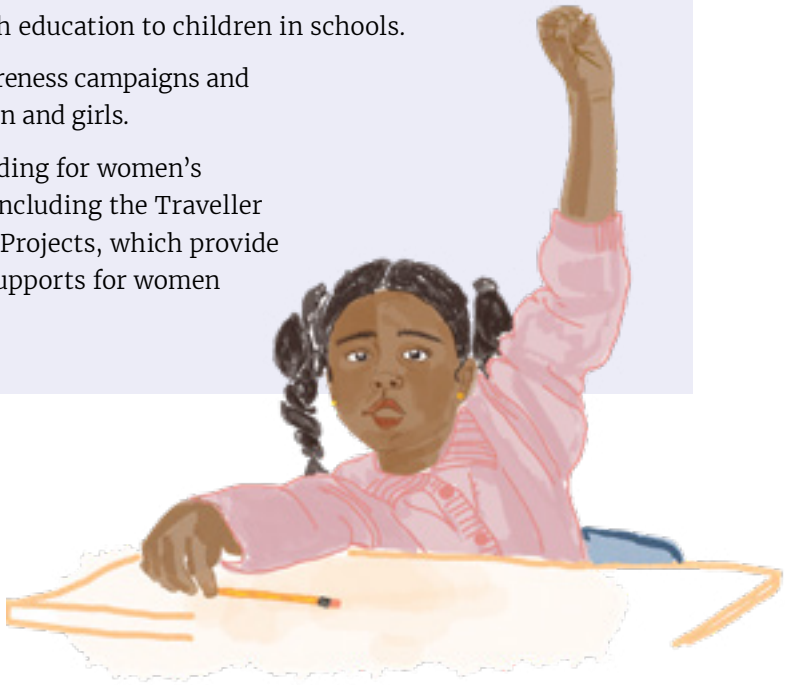
84 St Patrick's Mental Health (2018) *Attitudes to Mental Health Survey: Key Findings 2018.*

Women also identified the women's community sector as a source of ongoing support that improved their mental health and well-being. Women's community groups provided support through training, childcare and domestic violence services, as well as some specific specialist services. For Traveller women the Traveller Primary Health Care Projects (PHCTPs) were identified as a key support on the ground. PHCTPs provide an essential link between a community experiencing high health inequalities and a health service unable to reach and engage that community effectively. This was clearly evidenced in the All Ireland Traveller Health Study[85] which found that 83% of Travellers receive health information from Traveller organisations and PHCTPs.

***"This work is unrecognised, how women's groups support one another"*** (woman participant, Traveller women's group)

## WOMEN'S PRIORITIES

- Provide mental health education to children in schools.
- Develop targeted awareness campaigns and information for women and girls.
- Invest additional funding for women's community groups, including the Traveller Primary Health Care Projects, which provide vital mental health supports for women through their work.



85 All Ireland Traveller Health Study Team (AITHS) (2010) *All Ireland Traveller Health Study: Summary of Findings.*

## Training

Women identified that service providers needed a greater understanding of women's experiences and the impact that gender, trauma and culture can have on their mental health. More training is needed to ensure that health professionals deliver a service that is specific to women's needs.

***"Better training for all health professionals. GP's must be brought up to speed and better equipped to offer help instead of automatically prescribing drugs"*** (woman participant, women's community group 3)

### WOMEN'S PRIORITIES

- Provide all staff members working in mental health care, both specialist and primary care, with gender equality training[86].
- Provide anti-racism and discrimination training to all frontline health staff to ensure that services meet the needs of migrant and ethnic minority women.
- Ensure all health professionals receive training in trauma-informed care to increase awareness of the impacts of violence and trauma on women's mental health and minimise the potential of re-traumatisation[87].
- Collect data on women's use of mental health services. Include identifiers, such as ethnicity and disability, to ensure equality of access, participation and outcomes between groups of women.

86 HSE & NWCI (2012) *Equal but Different A framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery.*

87 Fallot, R. and Harris, M. (2018). *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol Community Connections*. Washington, D.C

## Adequate Supports

Throughout all conversation groups, women were incredibly frustrated at the level of support that is currently available at primary care level. It was clear that talking therapies/counselling were women's preferred intervention; however, they felt that there was an over-reliance on medication as a solution to women's mental health issues. Women believed that their experiences and mental health needs were not being listened to by health professionals.

***"You see a different person each time in the mental health service and you have to say the same things over and over again. I just want counselling but can't afford it"*** (woman participant, women's community group 1)

### WOMEN'S PRIORITIES

- Provide access to free counselling and talking therapies for women, particularly women with experiences of violence.
- Tailor supports to individual's needs. Ensure that women are respected, listened to and symptoms are taken seriously.
- Protect and ring-fence funding for community-based organisations which support women experiencing poor mental health.
- Ensure adequate services for mental health diagnoses that affect women disproportionately, for example; eating disorders and borderline personality disorder.

## Access to Mental Health Services

Inequity of access to mental health services had an impact on women in our conversations. Their experience of the two-tiered mental health care system included long waits for services, services only being available in some areas and difficulty accessing services which operated on a 9-5 basis due to their own caring responsibilities.

***"You try to access a service and you're told you have to wait 3 months. People in these services don't realise what that means when you hear you have to wait so long"*** (woman participant, women's community group 2)

### WOMEN'S PRIORITIES

- Create universal access to mental health services for all women, based on their needs rather than ability to pay.
- Ensure access to mental health services is not dependent on geographical location.
- Address barriers for women accessing mental health services, including recognising and supporting women's caring responsibilities.

# Conclusion

This project centres women's voices, putting the focus on their life experiences and their wisdom about keeping well and responding to their mental health difficulties. By hearing women's voices, and bringing their experiences out of the silence which has existed for so long, this project aims to contribute knowledge for how we can start to improve women's experiences of mental health services. This opening-up of the mental health conversation enables us to examine and understand the particular mental health issues women face in Ireland today.

There has long been a perception that women are better at dealing with their own mental health, that women don't bottle up their feelings, that women will seek support. These assumptions are overturned by what women told us about not feeling able to voice their mental health challenges for fear of judgement, or being turned away from over-subscribed services. What the women in this project told us chimes with concerns NWCI member groups have raised about the inability of the health service to take women's requests for support seriously and to provide the respectful and appropriate mental health supports women require.

At the same time, the enthusiasm and openness with which women met our request to participate in conversations tells us that women want to speak about their mental health. Women want to be asked. In more than one conversation, women spoke about revelatory moments when they were seeking support and a healthcare professional said ***'I hear you'***[88]. Having their concerns taken seriously and being told that support would be found was a profound moment. This seems to tie into a deeper silencing for women, in which they are conscious that society is not open to listening to women's mental health needs. Women appear to have internalised a message that you need to be satisfied when you've had a baby and experience a huge change in your life. Or, that as a woman you have to look after all those around you and push down your own feelings and anxieties. That society doesn't want to hear about your experiences of violence, which have left you with significant trauma, because these experiences are shameful and shouldn't be discussed. And a number of women also reiterated the message they have received from services that medication will be relied on to help them through, rather than a supportive long-term approach to working through their emotions and experiences.

The desire and the need to care for others was a deep thread in women's experiences of wellbeing. Many women talked about how conceptions of womanhood – tied to caring and mothering – impacted on their ability to respond to their own wellbeing. It also indicates that women, in providing support to members of their social networks, often older relatives or adult children, are shouldering significant responsibilities on behalf of mental health and social care services.

88 Woman participant, women's community group 1

This project has shown how varied women's individual life experiences, challenges and successes can be. It also identifies the shared issues coalescing around women's experiences of mental health and mental health services. These commonalities largely result from the inequalities women face – their caring responsibilities, the expectations society carries of women (body-image, being emotional, being socially connected), and their intersectional identities based on age, ethnicity, socio-economic status, etc. resulting in poorer health outcomes. In our conversations with a wide range of women – older, younger, rural, urban, Traveller, Roma, migrant, mothers, single women, working women – we gained insight into how mental health and wellbeing can be particular and individual. Life experiences and circumstances impact on the types of mental health difficulties a woman may have and on the resources she has available to get support. At the same time, we saw that women are conscious and considerate about the experiences of women who are living in different circumstances to themselves – young women thinking about the mental health of an older widowed woman, or women from rural Ireland expressing concerns about women living in Direct Provision centres. In this way, women were able to touch into a deeper female experience and to show solidarity.

If we want to improve women's health we need to listen and act upon what women tell us are the barriers they have to seeking help. That means addressing issues such as women's shame and guilt; the fear of their children being removed; depression or low self-esteem; experiences of racism and discrimination with service providers; and long waiting lists for care. To help a woman who is seeking assistance for their mental health we must first respect that she is doing the best she can, listen to her concerns and support her to develop additional ways of coping and to receive support from services.

The depth of knowledge provided through these conversations demonstrates women as experts in their experience of mental health and in strategies to improve women's wellbeing. Women's lived experience and know-how should be valued in the development of mental health services. Unfortunately, the findings of this project show that there are deficits in mental health provision for women which need to be addressed. We can and should address these deficits in tandem with recognising women's resilience and possibility for recovery. In NWCI, we will advocate to ensure that the opportunities in implementing a new national mental health policy and in developing a universal single-tier mental health service can be harnessed for the benefit of women.

Recognising the benefits of listening to women's experiences as a means to develop women-centred supports and services, this report focuses solely on the voices of women. We recognise that collaborative work to strengthen and develop the best mental health services and supports for women will also require an examination of service providers' perspectives. In collaboration with the HSE and other service providers, NWCI will seek to communicate what is happening within health, education, research and other sectors to improve women's wellbeing and to work with agencies to build supports where they do not currently exist. The development of a Women's Health Action Plan by the Department of Health, HSE and NWCI provides such an opportunity.

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