



Women and Mental Health: *Promoting a Gendered Approach to Policy and Service Provision*

Conference Proceedings



**WOMEN'S MENTAL HEALTH:
PROMOTING A GENDERED APPROACH TO POLICY AND
SERVICE PROVISION**

CONFERENCE

Jointly hosted by

The Women's Health Council

and the

National Disability Authority

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Opening and Welcome

Prof Cecily Kelleher, Chair of the Women's Health Council

Prof Kelleher said she was very pleased to welcome everyone to the conference, particularly thanked the Tánaiste, and Minister for Health and Children for agreeing to launch the WHC report on *Women's Mental Health: Promoting a gendered approach to policy and service delivery* and open this national symposium on women's mental health jointly hosted by the Women's Health Council and the National Disability Authority.

Prof Kelleher said that worldwide mental illness is associated with a significant burden of morbidity and disability, yet the mental health sector in Ireland is often referred to as the 'Cinderella' of the health services. Recent developments in the form of the publication of the Mental Health Act (2001) and the establishment of the Mental Health Commission are positive developments that should improve the quality of care currently being delivered. It is hoped that the recommendations of the Expert Group on Mental Health Policy due to be published in 2005 will update and improve the underlying approach taken in the diagnosis and treatment of mental health problems.

Prof. Kelleher said that the Women's Health Council report being launched at the conference provides evidence for the gender specific nature of mental health problems and their treatment, it substantiates the need for an improved knowledge base on mental health and illness in Ireland; and advocates for greater quality of care, and within that, increased equality of access to services¹.

According to Prof. Kelleher, the Women's Health Council also hopes that the report will inform and influence the current process of strategic policy formulation being carried out by the Expert Group on Mental Health Policy, and the Mental Health Commission on service delivery. She said that the Council was very pleased that Ms. Brid Clarke, CEO of the Mental Health Commission was one of the speakers at the symposium, and that Prof. Joyce O' Connor, Chair of the Expert Group on Mental Health policy was to close the day's proceedings.

Prof. Kelleher said she was equally pleased to welcome the keynote speaker Prof. Mary Seeman, an eminent psychiatrist whose research interest lies in the biopsychosocial differences between men and women, especially as they apply to psychotic disorders. She said she was also grateful that the other speakers have taken the time to join the symposium today to give an insight into the current situation in mental health care in Ireland.

Prof. Kelleher said that the Women's Health Council felt that the conference was an important stepping-stone in highlighting the need for gender sensitive

¹ The report is available on the Council's website at <http://www.whc.ie/publications/Women's%20Mental%20Health.pdf>

policies in the health sector, and hoped that the presentations and discussions to follow will bring greater focus on the gendered nature of mental health problems in particular.

Finally, Prof. Kelleher said she was pleased to present the report to the Tánaiste and that she looked forward to seeing its wisdom implemented.

Official Launch

Tánaiste Mary Harney, Minister for Health & Children

The Tánaiste said that she was delighted to attend the conference on Women's Mental Health, and that she was also delighted to see that there were six men in the audience. Mental health and illness is an important issue, and we have a long way to go to encourage men and women to be forthcoming and open regarding mental illness. The Tánaiste said that in examining the area, it is important to acknowledge that mental illness affects women and men in different ways, with women being more prone to depression for example. Women are also more likely to seek help and to talk about their problems than men are, and this is important as looking for help is the first step on the road to recovery.

The Tánaiste said that she watched the Late Late Show two weeks ago, when three women appeared who had each had a suicide in their family. She was struck by the fact that each of them said that the individuals concerned had appeared perfectly normal in the run up to their suicides and that they had given no outward signs that they were having difficulties. For this and other reasons, the Tánaiste stated that an honest analysis of what the problems and challenges are in mental health is needed if we are to address the problem properly. In this regard, she said she welcomed the report on women's mental health and thanked the Women's Health Council for producing it.

The Tánaiste said that it is also important to acknowledge that our mental state has an impact on our overall well-being, and that it can have a greater impact on us than anything else, giving us a negative perspective on work, relationships and so on. Therefore, she welcomed the preparation of the Expert Group's report analysing mental health, and said she very much looked forward to receiving that report. The Tánaiste stated that if Ireland is to have appropriate structures in terms of the resources that are going to affect mental health as we go forward, we need to have a correct diagnosis of what the problems are and what the issues are and how they should be addressed. More and more resources are going into the mental health area, but we have an awful long way to go, the Tánaiste said. From an environmental perspective, she said that the conditions in which mentally ill patients have been expected to reside are atrocious and would not be acceptable in other areas of the healthcare system. The Tánaiste suggested that Ireland is currently in a 'catch-up phase' as far as resources are concerned, and in this regard she mentioned the importance of both appropriate analysis and of investment based on this analysis.

The Tánaiste expressed her thanks to those who gave their time and expertise to putting out an analysis of the issues involved mental health. Unfortunately, she was unable to stay for the whole day today, as she was due in the Dáil, but she hoped to stay to hear for the first speaker and she wished participants well for the day.

Morning Session

Chair: Ms. Angela Kerins, Chair of the National Disability Authority

Ms Kerins thanked the Minister for her informed views and for her ambitions to improve mental health services in Ireland. She welcomed the participants and sign language interpreters to the conference.

Keynote address: Gender and Mental Health – The Canadian Experience

Dr. Mary Seeman, Professor Emerita, Department of Psychiatry, University of Toronto

In presenting her work, Dr Seeman aimed to fulfil the following objectives:

- To discuss Canadian gender-specific rates of mental illness
- To elaborate on Canadian knowledge about women's mental health
- To present Canadian evidence for gender-specific access to care, and the efficacy of gender-tailored treatment

The Canadian Government has adopted a Women's Health Strategy, which aims to

- increase knowledge about women's health
- promote the health of women
- support the provision of effective health services to women
- ensure that Health Canada's policies and programs are responsive to the differential needs of women²

However, Dr Seeman identified gaps that remain in the system in Canada: lone mothers, new immigrants who cannot easily access services, all disadvantaged women. There are also gaps in service provision relating to non-medical services, which are often needed for good mental health but not available, and relating to services for people living in geographically non-accessible or distant regions.

Canadian health services are moving away from hospitals towards care in the home – which effectively means care by women, since the majority of carers are women.

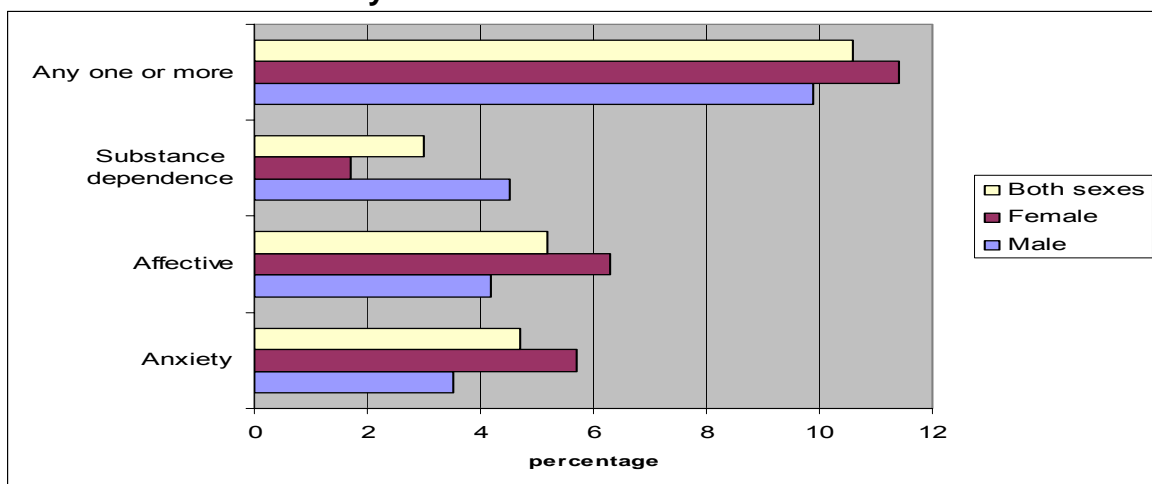
The mental health of women is affected by a whole range of sources, biological factors, such as hormones, but also by social factors. Women have been found to be much more vulnerable to a lack of supports than men, and the lack of supports for women is a major cause of depression. Women also

² Romanow, R. (2002). *Building on Values: The Future of Health Care in Canada*. Commission on the Future of Health Care in Canada. 28 November 2002. <http://www.hc-sc.gc.ca/english/care/romanow/>. Standing Senate Committee on Social Affairs, Science and Technology (2002). *The Health of Canadians - The Federal Role. Final Report. Volume Six: Recommendations for Reform*. October 2002. <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm>.

have an ambivalent relationship with food, often more so than men, leading to increased rates of eating disorders in women. In Canada, issues around food and eating have been found to affect girls as young as eight years old. Women are also at greater risk of poverty than men are, which can have a concomitantly negative effect on their mental health, and women also experience issues around lower role/social status and autonomy which negatively impact on their mental health.

Dr Seeman went on to describe the gender differences that occur in the rates of specific mental health problems. For example, depression affects three women for every two men (3:2 ratio), and anxiety also affects three women for every two men (3:2 ratio). Eating disorders are far more prevalent in women than men, with a nine to one ratio, and posttraumatic stress disorders, psychophysiological disorders, self-mutilation, and suicide attempts are also all more prevalent in women than in men³. With regard to the last example, women have been found to be more suicidal than men, although men are more likely to complete suicide as they use more lethal methods when attempting suicide.

12 Month Prevalence by Gender



Canadian Community Health Survey Mental Health and Well-Being, 2002

After looking at the prevalence of various mental health disorders by gender, Dr Seeman went on to look at some Canadian statistics regarding women and depression:

- Women 18 to 45 years of age account for the largest proportion of people suffering from depression.
- 20% to 40% of menstruating women experience premenstrual mood and behaviour changes.
- 10% to 15% of women experience a clinical depression during pregnancy or after the birth of a baby.
- There is a 3fold increase in risk of depression during or following a pregnancy among women with a history of mood disorders.

³ Seeman MV. 'Mental illness in women'. In: Goldman MB and Hatch MC (eds). Academic Press, San Diego, Ca. Ch 18 pp 989-996,2000

- Once a woman has experienced a postpartum depression, her risk of having another reaches 70%.
- 80% of women experience "postpartum blues"

She suggested that it is important to keep these findings in mind when designing services for women at risk of depression.

Prevalence of panic attack in past 12 months, by age group and sex, household population aged 15 or older, Canada excluding territories, 2002

	Both sexes	Men	Women
	%	%	%
Total	8.0	6.0	9.9[‡]
Age group			
15-24	11.8 [*]	7.4 [*]	16.4 [*]
25-34	10.3 [*]	7.2 [*]	13.3 [*]
35-44	8.6 [*]	6.8 [*]	10.4 [*]
45-54	7.6 [*]	5.8 [*]	9.2 [*]
55 or older [†]	4.2	3.9	4.4

Data source: 2002 Canadian Community Health Survey: Mental Health and Well-being

[†] Reference category

^{*} Significantly different from estimate for reference category ($p < 0.05$)

[‡] Significantly different from estimate for men ($p < 0.05$)

As with depression, there are also disparities in the data on gender and panic attacks. The incidence of panic attacks varies according to gender and also according to age; the rates are always higher for women than men, but those in the 15-34 age group appear to be most at risk for anxiety disorders.

Even where rates of mental disorder are similar, effects differ between women and men. This is true for a range of disorders including:

- Schizophrenia
- Bipolar Disorder
- Obsessive Compulsive Disorder
- Alzheimer's Disease

Dr Seeman pointed out that serious mental health disorders start on average five years later in women than they do in men. This means that with schizophrenia, for example, whereas men are likely to start exhibiting symptoms during their teenage years, women more commonly first experience the disorder in their 20s. This has serious practical ramifications, as women may already have children at this age so the onset of schizophrenia has serious implications for the women themselves and for their families, but also for mental health services. Mental health services will require strong links with child protection and care services, to ensure that mothers and their children are not separated unnecessarily.

With Alzheimer's disease, Dr Seeman pointed to the implications of women's longer life span, showing that women on average have to live longer with the

disorder than men do. Thus, women's longer life spans also have significant implications for health care services.

Even where rates of mental difficulty are higher in males, Dr Seeman pointed out, their effects on females may be more severe. This is true for a number of disorders including:

- Stuttering (girls often stutter more severely than boys)
- Hyperactivity and learning disorders
- Autism spectrum disorders (girls usually have more serious forms of autism than boys)
- Mental disabilities
- Addictions

Profound psychopharmacological differences have been found between men and women. These differences have shown that the effects of drugs can be quite different in women than in men, including in the following areas:

- Getting to the liver
- Getting into the blood stream
- Excretion through kidneys
- Getting into the brain
- Action at target site in brain - effect of male/female hormones on neurotransmitter systems
- Accumulation in fat stores
- Pharmacokinetic effects of pregnancy & lactation

Drugs have been found to stay in women's bodies for far longer than they do in men's bodies, and they also get to the brains of women and men at different rates. Women's and men's different tolerances for drugs mean that the same dosages are not appropriate for both, and Dr Seeman suggested that women can generally be given lower doses of drugs than men. Women and men have also been found to have differences in their compliance and adherence to drug therapies, and the side effects of drugs can be different for women than for men.

Dr Seeman pointed out that pharmacologic treatment is more complicated in women, for a number of reasons including:

- Menstrual cycles
- Contraception
- Pregnancy
- Breastfeeding
- Drug interactions
- Impact of side effects (e.g. sedation, hypotension) on parenting

Prescribers are usually not educated as to the psychopharmacological differences between men and women – Dr Seeman said that this is an area not usually covered in textbooks. In fact, she said, women are usually prescribed more drugs than are men, leading to further concerns about the

possibility of pharmacological interactions that may be harmful to women's health and well-being.

Dr Seeman went on to discuss evidence-based on-pharmacologic treatments for mental health. According to the results of research carried out by Dr Seeman and colleagues, 50% of women with depression seek help, 20% are treated with antidepressants, 10% are treated with tranquilizers and 20% receive no medications. A substantial proportion of women with mental health difficulties do not want drug treatment, but in Canada non-pharmacological treatments are not subsidized under the health care system so other options are costly to the individual. Some of the alternative treatments available include light therapy for winter depression, Transmagnetic stimulation for depression and for persistent hallucinations, cognitive-behavioural therapy, and interpersonal therapy.

With regard to use and access to mental health services, Dr Seeman stated that women require mental health services more frequently than men, receive treatment more often, are prescribed more medication, and have higher rates of hospitalization for psychiatric problems⁴.

According to Health Canada's Women's Health Strategy:

'All women, regardless of income, place of residence, domestic and employment responsibilities should be able to access appropriate mental health services'⁵.

With regard to appropriate mental health services, Dr Seeman discussed the findings of the 'Safe Minds' survey of one hundred women attending outpatient services at a clinic in Canada. Of the women surveyed, 70% expressed a preference for all-women groups (discussion, relationship, leisure activity, skill development, parenting, sex education), while 18% wanted an 'only-woman' space in the clinic. Of the women surveyed, 20% reported being approached in a sexual manner by a male patient, and within this group over 40% endorsed an 'only-woman' space

Dr Seeman moved on to looking at the links between gender and social inequality, and discussed the effects that social inequality can have on mental health. She pointed out that mental illness is associated with poverty, a fact of particular significance for women, who are disproportionately poorer than men (especially elderly women and single mothers). Poverty is also linked to violence and abuse; and poverty, violence, addictions and mental illness are strongly correlated⁶.

In reflecting on appropriate mental health services, it is also important to note that women are not a homogeneous group. Their needs vary according to age, immigration status, marital status, social class, ethnicity, religion, sexual

⁴ Rhodes AE, Goering PN, To T, Williams JI et al. 'Gender and outpatient mental health service use'. *Soc Sci Med* 2002;54:1-10.

⁵ Health Canada. *Health Canada's Women's Health Strategy*. Health Canada: Ottawa; 1999

⁶ Saraceno B, Barbui C. 'Poverty and mental illness'. *Can J Psychiatry* 1997;42:285-9. Morris M. *Women and Poverty*. Can. Institute for the Advancement of Women; Ottawa; 2002

orientation, homelessness and other circumstances⁷. For example, Dr Seeman stated that older women are more likely to age in poverty than men, to live alone, and to depend on poorly resourced chronic health care and social services. Social adversity contributes to high morbidity in psychoses in immigrants⁸. A woman's mental health needs may also change over her life course; Dr Seeman showed that in adolescence, the most common mental health issues are related to body image and eating disorders⁹, in childbearing years they are more likely to relate to pregnancy and postpartum depression¹⁰, and in old age the most common mental health disorder is dementia¹¹.

In order to create appropriate mental health services, Dr Seeman focused on the need to expand the evidence base and gather sex-disaggregated data - every country or region has different needs and each therefore requires its own evidence base to determine priorities for services. She said that as well as laboratory research in gender difference, research will be also needed in the areas of epidemiology; the effectiveness of treatments (including pharmacologic, psychotherapeutic, non-medical, self-help, peer support, alternative); health service access; the effects of poverty, violence and lack of autonomy; the effects of care-giving on (female) carers; and the secondary effects on children of mothers with mental health difficulties. Dr Seeman emphasised the importance of keeping up to date and not relying on old figures, and also of not assuming that what applies to men also applies to women.

Dr Seeman re-affirmed the World Health Organisation's list of the needs of people with mental health difficulties:

- Health promotion, prevention, early recognition
- Psychoeducation
- Medical, psychological, social, financial, spiritual and vocational support
- Crisis centres, Day care, Hospital beds (short and long term)
- Educational opportunities
- Family support
- Respite care
- Freedom from stigma, violence, and discrimination

However, Dr Seeman pointed out that women's social roles and circumstances meant that they have particular needs in the area of mental health. If these needs are to be fulfilled, attention will have to be paid to

⁷ Plouffe LA. 'Addressing social and gender inequalities in health among seniors in Canada'. *Cad Saude Publica*. 2003;19:855-60.

⁸ Health Canada (1999). *Canadian research on immigration and health: An overview*. Ottawa: Health Canada.

⁹ Bulik CM, Reba L. 'Eating disorders and body image in adolescence'. *Women's Mental Health - A Developmental Perspective*. Romans S and Seeman MV (eds) Lippincott, in press

¹⁰ Grigoriadis S. Postpartum and its mental health problems. *Women's Mental Health - A Developmental Perspective*. Romans S and Seeman MV (eds) Lippincott, in press

¹¹ Canadian Study of Health and Aging Working Group. Canadian study of health and aging: study methods and prevalence of dementia. *CMAJ* 1994;150:899-913

providing income supplementation, consumer-run businesses for women, safe and affordable housing or transitional housing. Women-centred programmes should also be provided to include physical and sexual abuse counselling, eating disorder programmes, reproductive mental health programmes and women's addiction treatment programmes. Family counselling, child protection, childcare and in-home services, women only services and mother-child units are also issues that must be taken into account when looking at women-centred mental health services.

Dr Seeman used the example of a women-only inpatient unit in Toronto, (the only one of its kind in Canada), to illustrate a model of best practice. The unit is actively developing women-centered approaches to care. As part of this brief, efforts are made to maintain and respect of the patient's autonomy within the limits of the clinical situation, and there is an emphasis on the validation of personal strengths as well as principles of empowerment, and egalitarian relationships. Many women who come to the unit have been abused in the past and therefore they are very sensitive regarding safety and the atmosphere in the unit. For these women, a women-only ward is very important. One way of making services more women-centred is to involve women in the process as partners. This involves fostering the capacity of women to participate in decisions about their health, and fostering the capacity of women to participate in research that pertains to them¹².

One of the biggest worries for women faced with mental health difficulties is the fear that their children will be taken into custody, and in fact Dr Seeman said that for seriously ill women custody loss rates can be as high as 70% to 80% in Canada. Separation from her children can undermine the mother's recovery, so it is most important to provide support to enable women to continue to parent. Such support could include advice on reproductive decision-making, perinatal health care, custody mediation (involving the family lawyer), teaching parenting skills and building family support and social networks.

In conclusion, Dr Seeman's overall recommendation was to **focus on women** and to look at the results of research through a gender lens. More specifically, Dr Seeman's recommendations were to:

- Utilize evidence base on gender-specific rates and course of illness, gender-specific symptoms, gender-specific interventions
- Expand evidence base
- Apply gender-based analysis to evaluation of outcomes and policy and program development
- Strengthen mental health in primary care with special attention to maternal mental health

¹² Kirby M. *The Canadian health care system - Options for Reform paper presented to the Dialogue on Health*. Government of Canada: Ottawa; 2001
Romanow R. *Building on values: The future of health care in Canada*. Commission on the Future of Health Care in Canada: Ottawa; 2002

Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision

Ms Alessandra Fantini, Policy Officer, The Women's Health Council

Before starting her presentation, Ms Fantini highlighted the need to take great care when talking about 'mental illness'. She stated that during the course of her presentation she would be using medical terms for the sake of clarity.

With regard to her objectives for the presentation, Ms Fantini said that she would begin by outlining the incidence of mental health problems nationally and internationally; she would then provide a brief overview of current mental health policy; move on to make the case for the gendered nature of diagnosis and treatment, illustrating the theories for these gender differences; present the current situation in the most relevant mental health care setting for women and finally advocate for an improved model of care for women affected by mental health difficulties in Ireland.

Looking at incidence rates, Ms Fantini drew attention to international data, which show that mental illness affects between 20 to 25% of all people during some time in their life. She pointed out that one in four families in the world has at least one member with mental health difficulties; and four of the six leading causes of disability are due to mental health problems (these are depression, alcohol abuse, schizophrenia and bipolar disorder). At European level between 15% and 20% of adults have been found to experience some form of mental health problem. Because of these statistics, the European Union has chosen mental health as one of its priorities for its Public Health Programme (2003-2008), and the new EU Commissioner for Health, Mr. Kyprianou, recently called mental illness "Europe's unseen killer".

In Ireland, unlike in the USA, Canada and the UK, there are no community mental health surveys. Ms Fantini said that this lack of data significantly limits any analysis of mental health and mental illness prevalence at population level. However, she stated that the Department of Health and Children has estimated that 10% of the general population is affected by depression, and 1% by schizophrenia. In Ireland at inpatient level, there were 23,031 admissions to psychiatric units in 2003, representing a rate of 760.4 per 100,000-population aged 16 years and over. Ms Fantini said that this was a slight decrease from 2002, but that it is still a high rate for a developed country.

Despite this high rate, while physical health has received considerable attention by government and professional bodies, the importance of mental health is often neglected, and Ms Fantini said that the mental health sector in Ireland is often referred to as the 'Cinderella' of health services. She also drew attention to the fact that the current attitude towards mental health provision has been described by Dr. Teresa Casey, the new Inspector of Mental Hospitals, as "a culture of making do" which devalues people affected

by mental illness, discourages them from accessing services, and contributes to the stigma attached to them.

The Women's Health Council hopes that this situation might improve soon. A number of positive and welcome developments have taken place in recent years, such as the publication of the Mental Health Act (2001), the establishment of the Mental Health Commission in April 2002 and the setting up of the Expert Group on Mental Health Policy in August 2003. The Expert Group will be making recommendations for a new Mental Health Policy to replace the 1984 *Psychiatric Services - Planning for the Future* document.

Ms Fantini stated that mental health services in Ireland are currently gender-neutral at best, and skewed towards the needs of the male population at worst. She pointed to the fact that even the most recent government health strategy, *Quality and Fairness* (2001), the section on mental health made no reference to gender. Furthermore, mental health was mentioned as a concern in the section on men's health, but it was not mentioned for women.

In the Government's women's health policy, *A Plan for Women's Health 1997-1999*, mental health services are described as not being in a position to offer women support for their mental health needs. Ms Fantini argued that if the specific mental health needs of both women and men are to be met, it is paramount that the Expert Group on Mental Health Policy and the Mental Health Commission adopt a gendered approach.

Moving on to focus on the gendered nature of mental health problems, their diagnosis and treatment, Ms Fantini emphasised the over-representation of women in prevalence studies of mental health problems. She explained that this situation has been attributed to historical views of women as inherently irrational and mentally weak. However, Ms Fantini suggested that new definitions of mental illness, which include behavioural problems as well as the traditional categories of cognitive and emotional difficulties, have rectified this situation. Hence, women and men are now thought to be affected by mental health problems in equal measure, but by different types of difficulties.

Ms Fantini stated that gender is, therefore, a critical structural determinant of mental health and mental illness that, to quote the WHO,

"...runs like a fault line, interconnecting with and deepening the disparities associated with other important socio-economic determinants such as income, employment and social position".

One of the most robust epidemiological findings worldwide is that women are affected by depression at twice the rate of men. Ms Fantini pointed out that women are also more likely to receive a diagnosis of "panic disorder", "generalised anxiety disorder", "obsessive-compulsive disorder", "post-traumatic stress disorder" and are more likely to attempt suicide. Over 90% of cases of eating disorders occur in women.

Looking at men, Ms Fantini said that they are twice as likely to be affected by alcohol or drug abuse, three times more likely to be diagnosed with "antisocial

personality disorder”, and are more likely to commit suicide. There are no differences, however, in the rates of severe mental illnesses like schizophrenia and bipolar depression.

Ms Fantini re-iterated her point regarding the lack of mental health community surveys in Ireland and pointed out that this means that all data on the prevalence of mental health problems comes from in-patient surveys. She said that these data are therefore likely to be disproportionately skewed towards more severe mental illnesses that cannot be addressed within primary and community care.

Looking at the information that is available, however, Ms Fantini discussed the findings of the Daly and Walsh of the Health Research Board in their report on the *Activities of Irish Psychiatric Services 2002*¹³. She said that diagnoses did follow a predictable gender pattern. Rates of depressive disorder were higher in the female cohort. This is particularly significant because a high number of cases would be treated through primary care, and not require hospitalisation. Alcoholic disorder and drug dependence rates, on the other hand, were higher in the male cohort. More males than females were admitted for schizophrenia, despite general equality of prevalence in community studies. Ms Fantini suggested that this higher rate of male admissions might be related to society’s gendered perception of men as more dangerous, and it is reflected in the fact that males also had a higher rate of involuntary admissions. She pointed out that a severe social gradient was also visible, with highest rate of hospitalisation among the lower-income groups.

Ms Fantini then went on to discuss the possible reasons for these differences. She said that a number of theories have been proposed and can be subdivided into three broad categories: ‘women’s bodies’ or biological theories, ‘women’s personality’ or psychological theories, and ‘women’s lives’ or social theories. However, Ms Fantini stated that a framework that incorporates all of them, i.e. a **biopsychosocial** model, is the most likely to provide the best explanation for the gendered nature of mental health and mental illness.

Biological theories underpin the ‘medical model’, and usually refer to the concept of genetic inheritance and the role played by women’s physiology in the aetiology and manifestations of mental illness. Scientists have claimed that genetic inheritance may account for up to 50% of the risk of major depression, and have recently identified a genetic variation that might be linked to women’s susceptibility to this illness. Hormonal factors have also been blamed for women’s higher levels of depression. However, Ms Fantini pointed out that the huge cross-cultural variations found in rates of depression call into question any simple hormonal explanation for women’s high rates of depression.

¹³ The report for 2003 was published after the research took place, but its findings are broadly in line with those presented here.

Ms Fantini then cited research which suggests that the impact of biological and reproductive factors on women's mental health is mediated or even subsumed by psychological and social factors. When examining gender differences in psychological development, she said that the effect of gender-specific socialisation and coping patterns seem particularly significant. In this regard, Ms Fantini noted that throughout their lives women in Western culture are encouraged and expected to be more nurturing and to value outside opinions more, while men are thought to be 'naturally' more independent and self-reliant and are not expected to be caring or emotional. Another theory suggests that women tend to have a more self-focused ruminative style of coping with negative feelings, while men are thought more likely to pursue distracting activities in similar situations. Alternatively, it has been argued that girls are encouraged to internalise their stress whereas boys are encouraged to act out their stress.

Finally, Ms Fantini stated that the particular influence that social factors exert on mental well-being couldn't be underestimated. Morrow and Chappell claim that "Women's mental health cannot be understood in isolation from the social conditions of [their] lives", and it needs to be contextualised within them. The 1998 WHO World Health Report states that women's health is inextricably linked to their status in society. It benefits from equality and suffers from discrimination. Women's status in society is still lower than men's even in developed countries, and this is certainly the case in Ireland.

Apart from their lower social status, Ms Fantini pointed out that women are also disadvantaged by the multiple roles they perform in society as carers, partners and workers. This situation has been found to cause women considerable amounts of stress. The stress is generally caused by the well documented imbalance in caring responsibilities within couples, where women are usually considered the primary carers and are responsible for parenting and any other caring duties towards ill or elderly relatives regardless of whether they are employed or not.

Throughout their lifetime, Ms Fantini noted that women are also more likely to be affected by stressful events, especially in relation to physical and sexual abuse, which can cause serious physical and mental health repercussions. In Ireland, a study conducted by the Dublin Rape Crisis Centre in a representative sample from the general population, found that 1 in 5 women had experienced child sexual abuse, and 1 in 5 women had also been sexually assaulted as adults.

The psychological and emotional strain caused by social factors is further exacerbated by social disadvantage. Ms Fantini said that a reverse relationship has been found between socio-economic status and mental health. Worldwide, women are consistently poorer than men due to their lower levels of education, lower rates of pay, doing more part-time work and thus being less likely to ensure a financially secure old age. This situation holds true in Ireland, too, where women have been consistently found to be at greater risk of falling into poverty than men. Worryingly, Ms Fantini pointed out that the gap between the genders has been widening in recent years.

From her discussion on how mental health difficulties are influenced by gender, Ms Fantini then moved on to show that gender also affects women's and men's patterns of help seeking and treatment.

According to her research, Ms Fantini said that women are more likely to seek help from their primary health care physicians. In turn, their GPs are more likely to prescribe them drugs rather than refer them to psychiatric services. It is estimated that women throughout Europe and North America are prescribed approximately twice as many psychotropic drugs per head as men. Men, on the other hand, find it difficult to seek help and are often seriously ill before they access medical services. They are then more likely to be referred to specialist mental health care. Having accessed the services, women are more likely to recover from severe mental illness and men are more likely to be heavy users of psychiatric services, experience long-term hospitalisation, and be admitted against their will. This trend again stems from a gendered perception of men as more dangerous. Hence, treatment models that are not based on gender stereotypes but actually address the realities of gendered experience are likely to be more beneficial to both women and men.

Ms Fantini then looked again at treatment in Ireland, and explained that no gender-disaggregated information is available in relation to treatment at either primary or secondary level. The only documented statistics point to the greater number of men receiving inpatient public care (54% for health board hospitals and 53% for general hospitals psychiatric units), and the greater number of women receiving inpatient care in the private sector (57%). No analysis of these statistics is available, but Ms Fantini suggested that it might be inferred that the over-representation of men in inpatient care is linked to their delay in seeking treatment until the problem has become very serious, and to society's perception of their greater dangerousness. On the other hand, she said that the overrepresentation of women in private hospitals might be related to the particular services offered there, for instance, specialised treatment for depression and eating disorders. The scarcity of information at our disposal greatly limits any further analysis in relation to treatment and service provision. Nevertheless, Ms Fantini stated that the high rate of inpatient re-admissions, which reached 71% in 2003, clearly points to the absence of lasting benefits from hospitalisation, and the lack of health and social supports in the community.

She then moved on to provide a brief overview of the current situation in relation to mental health service delivery in a number of different settings, which have been found to be most relevant to women's experiences and needs.

As mentioned, no comprehensive data are available in Ireland in relation to treatment and service provision at primary level. This lack of information is particularly worrying, as general practice is usually the first point of contact for people experiencing mental health problems. Ms Fantini drew attention to an innovative study of mental health care in general practice, carried out in the South Western Area Health Board by Coptly on behalf of the Irish College of General Practitioners in 2004. This study paints a very bleak picture in relation

to the quality of care currently being provided to the Irish public, despite the fact that 10 to 20% of primary caseload fell under the category of mental health in that area. Coptý found that 68% of GPs had received no specific training in mental health, and agreed that they lacked specific skills in detecting, diagnosing and treating mental health conditions. This lack of training should raise serious concerns, given that when they are diagnosed with a mental health problem, women are more likely to continue receiving treatment within primary care.

The 3 most prevalent mental health conditions were found to be “anxiety disorders” (49%), depression (24%) and emotional difficulties (20%) (Coptý, 2004). Based on epidemiological data, it is rather safe to assume that women would be over-represented in these categories. Only a small percentage of patients were referred to mental health specialists, and, as women are most likely to be treated with psychotropic drugs, those are probably mostly men.

While the reliance on psychotropic drugs for the treatment of depression and anxiety is well documented both internationally and in Ireland, different reasons have been given for this situation. Some commentators draw attention to the ever-increasing influence of pharmaceutical companies. It has also been argued that it is the lack of alternatives that draws GPs toward a pharmacological solution. However, as Dr. Walsh recently claimed, there is no evidence that the widespread increase in the prescription of antidepressants has resulted in a decrease in the incidence of depression.

Therefore, Ms Fantini stated that it is vital that GPs critically assess the appropriateness of prescribing psychotropic drugs as a first recourse, and, before doing so, consider the use of other options, which have been found to be beneficial and are preferred by women, such as counselling. However, the vast majority of GPs in Coptý’s study (81.5%) indicated that they would like to have access to counsellors or psychologists but do not at the moment. The institution of multidisciplinary primary care networks, which include a psychologist, as recommended in the Primary Care Strategy, would hence be a welcome development. The Women’s Health Council would urge the Department of Health and Children to allocate the necessary funds towards a speedy implementation of this strategy.

Looking at community care, Ms Fantini said that the only data available in relation to community care in Ireland deals strictly with admission rates, which are disaggregated only in terms of the old health board areas and, thus, cannot provide any information on social variables, diagnoses, treatments or recovery rates. However, she pointed out that the ability to receive treatment within a community setting has a number of clear benefits from a user point of view: stigma is reduced, and disruption to social and working life are minimised (Owens, 2004). Johnson claims that

“The wider, more flexible and more accessible range of services that can be offered through community care are more helpful to women with mental health problems” (1996a: 1).

The UK official mental health policy for women advocates the use of community day centres staffed by women to provide safe, confidential and open-access services. The range of services to be offered would include counselling, group-work, self-help groups, complementary therapies and educational programmes. Based on the international recognition of the benefits of a community care approach, the Irish government incorporated this view in its mental health policy published in 1984, *The Psychiatric Services - Planning for the Future*. However, twenty years on, Ms Fantini pointed out that community care services in Ireland are still lacking, especially in relation to basic outpatient treatment facilities like day hospitals and residential units. Furthermore, the inpatient model of care is still the dominant area of interest of many care providers. Hence, more needs to be done to redirect mental health service provision towards community care both in terms of home-based treatments and community facilities.

While the benefits of community care have been highlighted, Ms Fantini said that it is unlikely that the need for inpatient care will disappear in the future. Moreover, hospital admission also has some positive effects for women as it can offer respite from stressful personal circumstances. However, women in general have been found to experience psychiatric hospital settings as punitive rather than therapeutic. Dr. Owens, Chairman of the MHC, stated that “Women in particular find their inpatient stay intimidating”. In order to remedy this situation, many districts in the UK are now establishing single sex acute wards. These are especially important for women survivors of violence and to prevent further victimisation. The recent UK mental health policy for women recommends all residential settings to provide single sex accommodation, toilet and bathing facilities, and a woman-only lounge, and to pay special attention to women’s safety, dignity and privacy. Mother and baby units should also be made available.

As the Irish system is still dominated by the inpatient model, appropriate services for women are paramount within a hospital setting. Treatment in public hospitals is based on a medical model of mental illness dominated by psychiatrists. Ms Fantini stated that while the use of multidisciplinary teams is advocated, very few are actually able to deliver this type of care and most rely heavily on medication. In addition, or, arguably, because of this medical model, she said, many patients in Irish psychiatric hospitals feel excluded from treatment decisions, find their time in hospital stressful and stigmatising, and paradoxically, often have reduced access to their therapists. Hence, greater awareness of women’s needs to be promoted alongside a more person-centred approach.

Finally, there is evidence to support the claim that women who are receiving mental health care in inpatient settings are being discriminated against in terms of physical health. In the 2002 Report, the Inspector of Mental Hospitals claimed that long-term patients had not participated in Breast Check even in those areas where this service was available. This situation should be rectified and all inpatients should have access to physical screening and treatment programmes like the rest of the female population whenever clinically possible.

Ms Fantini then presented the Women's Health Council recommendation: a gendered sensitive model of care for women. She said that the Council has advocated a multi-disciplinary service based on a **community care model**. Kohen argues that a comprehensive mental health service for women should be based on the collaboration of well-integrated, tiered services ranging from local self-help and voluntary groups to community facilities attached to general practice surgeries. Moreover, community mental health teams or specialised rehabilitation teams should be closely linked to inpatient and outpatient statutory services, the social services and secondary and tertiary care providers.

The Council also believes that a **person-centred approach** in which women's specific mental health concerns and life priorities are taken into account also needs to be adopted. Moreover, an element of choice and self-determination needs to be present. Consideration for the many social roles that women perform, as partners, workers and, especially, as parents, is also paramount. In fact, as Dr Seeman also noted, fear of losing custody of their children is one of the main barriers for women accessing services, while maintaining their custody has also been found to be critical for recovery.

A **holistic approach** also plays a vital role in the treatment of women's health issues. Therefore, attention must also be paid to women's physical health. It is now established that depression is a risk factor for cancer and heart disease. Mental illness has been associated with a significant risk for any cardiovascular disease, especially in menopausal women. This is especially significant within an Irish setting, where cardiovascular disease is the most common cause of death for women.

The voices of current and past women users of mental health services must also be heard within service delivery, Ms Fantini stated. Women users should be involved in commissioning services, participating in patient councils, playing a part in their own care and treatment decisions, and contributing to clinical governance. While **advocacy services** for people experiencing mental health problems are currently underdeveloped in Ireland, awareness of their need has increased, and a group of NGOs has formed the Alliance for Mental Health. However, Ms Fantini suggested that a coalition specifically championing the concerns of women should also be instituted.

If mental health services are to improve for anyone, Ms Fantini stated that the issue of inequity of care must be resolved. Inequities are evident in Ireland both in geographical and social terms. The Irish Psychiatric Association has described a situation in which mental health resources have been developed in areas with greatest affluence, rather than greatest need. The varying standards of services across the country have also been criticised by the Irish College of Psychiatrists. The needs of disadvantaged women, who are by their socio-economic position more prone to experiencing mental health problems, should be considered, and services made available that do not discriminate against them in terms of access and availability.

Ms Fantini highlighted throughout the presentation, one of the most pressing needs in relation to mental health services in Ireland is the availability of data at community level covering both general mental health and the prevalence of mental health difficulties. She pointed out that without this evidence-based evaluation, no improvement to current models of treatment and service provision will ever occur. Moreover, any data collected in the future should be disaggregated according to the nine grounds laid out by the Equal Status Act. Because of its strong link with health and access to services, special attention should also be paid to socio-economic status.

Looking at the data that does exist in Ireland, Ms Fantini said that there is clear evidence that women and men are affected by different mental health problems, and experience them in different ways. Moreover, the treatment of mental illness is influenced by gender just as much as its diagnosis. It follows that treatment programmes and service provision need to adopt a gendered approach in order to be effective.

Adequate funding is also crucial if improved mental health services are to be provided for anyone. At the moment, Ms Fantini noted that mental health services in Ireland are grossly under-funded, so it is to be hoped that the situation will improve soon.

Finally, Ms Fantini said that the Women's Health Council hopes that the evidence presented at the conference and contained in the position paper being launched will inform the work of the Department of Health and Children, the Health Service Executive, the Mental Health Commission, the Expert Group on Mental Health policy, and all people working in mental health care. Moreover, the Council wishes to encourage policy makers and service providers in other relevant areas, such as social services, education, employment and housing, for instance, to be aware of the effect that their decisions have on women's mental well being. If the intent is to improve women's mental health as well as the care they receive when experiencing mental health problems, Ms Fantini concluded that what is required is a gender specific mental health policy combined with a coordinated intersectoral approach.

Questions & Answers

Panel: Dr. Mary Seeman, Ms Alessandra Fantini, Ms Angela Kerins (Chair)

- Participant asked about the mental health services for ethnic minority women and women who have experienced racism. In Ireland the emphasis is on doctors without services such as counselling, and the participant wondered how the needs of indigenous women are provided for in Canada?

Dr Seeman said that health of indigenous women is an interesting one. Although healthcare in Canada is organised mainly on a provincial basis and provincial plans only cover medical services, indigenous healthcare falls under federal government and covers non-medical services to a far greater degree. Federal plans for health in Canada cover more than just medical services, and they make it possible for indigenous women living in geographically accessible areas to avail of a wider range of services than other non-indigenous women. However many indigenous women live in geographically remote areas, and for them access to services is obviously a problem. There is an advantage for indigenous women living in big cities, for example, because all their health care is covered including psychologists, social workers, etc, possibly even massage therapists and other non-medical services.

- Participant commented on the current structure of the mental health services, which is not women-friendly in its general culture. One example of this is the lack of social research on health and mental illness – areas that could be women-friendly are not the things that are addressed by the main health research funders. He asked the panel for their comments.

Ms Fantini agreed that research is a big issue –the benefits for service users of both qualitative and quantitative research must be recognised in this regard. A shift in thinking is required, as funders often want numbers – they want statistics, things they can evaluate clearly – so initially what needs to happen is a paradigmatic shift in the way that people interpret the value of qualitative research. If that did happen, then what the participant referred to as the more women-friendly areas, would be more likely to be researched and valued. At present in Ireland we have numbers available but it is the difference in lived experience of mental health that should inform the types of services being provided. We need a balance of the different types of research and the different benefits that they provide in order to implement an effective mental health service.

- Participant drew attention to the range of diversity issues that may be experienced in tandem with mental health difficulties. In particular she asked about women with disabilities who also have mental health difficulties, who have particular needs in relation to mental health. For

example, the participant said that the mental health issues of Deaf women are often be made worse by their disability – due to misunderstandings, fear of losing their children is greater because of the lack of facilities, and there is often no one to tell them how to take their medication so they just do not take it at all. Deaf women also experience isolation because of their lack of access to communication, misdiagnosis and improper treatment. Participant would have liked to see more focus on these kinds of issues in the morning's presentations.

Dr Seeman apologised for not making any reference specifically to mental health services for the Deaf in her presentation. In large Canadian cities there have been quite a few mental health initiatives and services especially for Deaf people. Dr Seeman said she was particularly grateful to the Hearing Society in Toronto, an organisation which provides services for Deaf people, but also provides volunteer placements for non-Deaf people with mental illness. It is one of the best employment opportunities for severely mentally ill people, giving them an opportunity to start back to work through volunteering. There are services for Deaf people with mental health difficulties in Toronto, although Dr Seeman said she was not sure about services in the rest of Canada.

Ms Fantini also apologised that she did not have the time in her presentation to look at specific groups of women who have been found to be particularly disadvantaged and most socially excluded. However, she drew attention to the section in the Women's Health Council report specifically dealing with disability and other sections on the needs of various vulnerable groups of women in Irish society. Unfortunately time limitations meant that all of this data could not be included in her presentation.

- Participant emphasised the problematic nature of the lack of emphasis on and support for recovery within current mental health service provision in Ireland.

Ms Fantini agreed, and drew attention to the Women's Health Council's recommendation around providing transitional housing complete with access to relevant services in this regard. There is nothing in the community at the present time that aims to help people recover, or to provide follow-on support for people being released from hospital care. There is therefore a need for back-up, empowering support – provided by support groups, for example.

- Participant raised the need for women-specific units/wards/services, and for making community-based treatment services a priority, rather than focusing on large acute services.

Dr Seeman said that in Canada the emphasis is now moving out of hospitals and into the community - there are fewer and fewer hospital beds being provided for mental illness, and most care is now provided in community settings. Innovative services are also being developed, for example, small mental health clinics in medical buildings, which reduce the stigma associated

with attending mental hospitals. Travelling mental health services are also provided in some places (similar to the travelling libraries in Ireland). Dr Seeman said that in Canada they do, therefore, have different venues for mental health, but what they still need is different philosophies.

Ms Fantini agreed that need for community care for mental health should be emphasised. However, she said it was also important to note that if hospitals are to remain in use then it is essential that they be changed and improved.

- Participant raised concern about the dearth of information and policy on foetal alcohol spectrum disorders in Ireland.

Dr Seeman said that alcohol and substance abuse are an enormous and unresolved problem among the indigenous people in Canada also. She said that there are 'epidemics of suicide' among the young people in these populations, probably related to substance abuse in their parents. The health services in Canada still have not found a solution to these problems, and continue to struggle with them.

- Participant noted the prevalence of domestic violence and its effect on mental health, and brought up the need for more interagency links and centrally organised referral programmes for all involved in the mental health area, as well as GPs and other relevant personnel.

Ms Fantini agreed that interagency links and referral programmes are all most important, and said that she would also advocate co-operation with the NGO sector that provide specialised expert services. However, she pointed out that these services often suffer from lack of funding and lack of co-ordination, issues that need attention. An increased awareness of violence against women is also needed.

- Participant raised the need to address the infrastructure of the state that provides services to women, to include the provision of childcare, services for carers, and services for recent immigrants. She made the point that there has been little investment in services for women, and this is a major mental health and well-being issue.

Ms Fantini agreed, and further pointed out that women have been found to experience the highest levels of work stress probably due to their multiple social roles and caregiving duties. This area has been covered in some depth in the Women's Health Council report.

Dr Seeman pointed to the example set by other European countries in the area of maternity leave, and suggested that maternity leave should be available to women on a paid basis for one year after they have given birth.

- Participant noted the particular effect of disadvantage on women's physical and mental well-being. In this regard, he noted that that almost 60% of the clients of the Monetary Advice and Budgeting Service (MABS) are women, the vast majority of whom have physical or mental

health problems. He also raised concerns about the correlation between social exclusion and mental illness, the role of indebtedness in mental illness, and the role of social protection.

Ms Fantini agreed, and noted that socio-economic status has been found to be one of the main determinants of mental health.

Dr Seeman said that in Canada a disability pension is available for people with disabilities, however one condition of accessing the pension is that the person is not in paid employment. She said there is hence no way to get out of debt if you are on a disability pension, as you would lose it if you took up paid employment.

- Participant made a point about the influence of pharmaceutical companies, and the incentives they offer GPs that may result in encouraging over-medication and over-prescribing.

Ms Fantini said that the influence of the pharmaceutical industry certainly does raise concerns, but said that until GPs can offer alternatives there is not much chance of change. For these reasons, GPs need access to psychiatrists in Primary Care Teams, and should also be able to refer patients on to counsellors.

- Participant raised a concern about the appropriateness of women-only services/units, and the possible stigma they might cause.

Ms Fantini said that services should be based on and organised around women's preferences, a subject that needs more examination in Ireland. It may be that Irish women do not want women-only services, but until the research has been carried out there is no way to know this for sure.

Dr Seeman said it is important to look at the type of women-only service being provided – where it is located and what it looks like. Women will not avail of women-only spaces if they are not pleasant places to be. As infrastructure is often a problem, one solution is to allocate particular times that a room will be 'women-only' or 'men-only', allowing efficient use of a space.

Afternoon Session

Chair: Ms. M. Claire O'Connor, Director, National Disability Authority

The Lived Experience

Ms. Mary O'Shea, Mother and Service User

Ms O'Shea said that rather than starting with the onset of her illness, she had decided to talk about her life beginning in childhood. She grew up in a country area, and was born into a working class family with two brothers and two sisters. She said that her mother was diagnosed with manic depression just after Ms O'Shea herself was born, and that as a result her mother took pills all her life. She herself swore that she would never take tablets if there was anything wrong with her when she grew up. Ms O'Shea's father was a heavy drinker, so she grew up in an atmosphere of tension and nervous energy. She went to school in the local town, and from around the age of nine she was sent to her aunt, to work in her bar. She did her Leaving Certificate in 1975, and at that time her ambition was to travel, so she went to France for six weeks to pick grapes.

On her return Ms O'Shea said that she did a number of different jobs; she worked in a nursing home for a while, in a bookies office and then she became interested in the Prison Service so she applied and was accepted for a job, and worked in Limerick Prison for eight years. She also moved out of home at this time, living in a house with some other girls, and then she met her husband. They got married in 1982, and had three children. The marriage was good for the first few years, she was very happy and loved her husband dearly. While her children were young, Ms O'Shea went back and did Leaving Certificate English, as she loved English, and then did a course in Women's Studies. After her third child, however, she experienced mental health difficulties. She didn't need medication at that stage, she was lucky as there was a mental health programme available in a nearby town and she got great support there and thought she had recovered.

After her children went to school, Ms O'Shea decided that she would like to go back to work; she found her time at home very long and missed the company of workmates. She wanted to be with her children during the summer holidays, so she decided that she would do a bus driving course and train to be a bus driver. She thought this would be an exciting and challenging job. She took up employment with Bus Eireann and drove a school bus – the one her children were going to school on so it was lovely and it meant she could be there for them in the summer as well.

Shortly after taking up the bus driving job, Ms O'Shea said that her marriage ended. She said she was not sure if her illness was coming on at that stage or if her marriage difficulties were causing the illness, she was not sure which came first. Either way, her marriage broke up and she and her husband went

their separate ways in April 1994. The following January she had another bout of depression and she gave up the bus driving job that she had loved so much. She was then at home full-time and she was on her own every day so gradually she went into a state of paranoia and fear. One evening her ex-husband came to pick up one of her children and she just told him even though she loved the children dearly she just couldn't cope so she asked if he could take the children and the dog. He told her she needed help because she was screaming and shouting at him out at the car, so she went to her next-door neighbour and asked him to drive her to the hospital. That was her first experience of hospitalisation.

The first thing she was given – and she can still distinctly remember the taste – was largactil¹⁴. It was her first time being medicated because she was into health, homeopathy and holistic medicine. She spent around three weeks in hospital, and then returned home on her own (the children were with their father). A social worker called to see her after she was realised and during the visit said 'You realise you have schizophrenia?' – that was the first time Ms O'Shea had been told and it came as a complete shock to her. She said she may have been told in the hospital but she was not very clear in her thinking during her time there and she had no recollection of being told previously.

Ms O'Shea said she did not feel able to look after her children at that time, so their father took care of them on a full-time basis and she visited them in his house. She felt her feelings were blunted at that time, she said she had a huge lack of feeling. She really wanted to find out about and meet other people with mental health difficulties, particularly schizophrenia, so she went looking and came into contact with Schizophrenia Ireland. She went along to the first meeting of a care group being established in Ennis. After the facilitator left, Ms O'Shea herself kept the meetings going and eventually she was asked by Schizophrenia Ireland if she would take over the job officially, so she did. Five years on she is still facilitating the meetings in Ennis. Initially they used to meet up with the Galway group and go on weekends and other social outings funded by Schizophrenia Ireland, and they now have flag days to raise their own funds. The one thing Ms O'Shea said she noticed about the support groups was the greater proportions of men who take part; in the Galway group there are around fourteen men to two women, and in the Ennis group there are about six men to three women. She said she wondered why women are not accessing the support groups more – she does not know what the reason is and she has never looked into it, but she would like to find out.

Ms O'Shea said that they have a very good Development Officer from Schizophrenia Ireland in the Mid-West – Anne-Marie – and she got funding from Combat Poverty for their group. They have a Women's Network starting now – it is still in its infancy – to bring women with mental health difficulties together. They do workshops, role play and get a weekend away, it is very interesting and helps women make new friends. However, they do need more funding now to keep the network up and running. They have also previously

¹⁴ MIMS Ireland for January 2005 describes this as a drug used for 'Central Nervous System disturbances requiring sedation, schizophrenia, and other psychoses' (p80).

made a radio documentary that was aired on Tipp FM, and made a cartoon that was shown at the Cork Film Festival.

Ms O'Shea said that after her first episode she was on very little medication and she was getting on fine, but she still wanted to reduce her medication and come off it altogether. She reduced her medication to just one tablet a day (she had been on two), and she was going along fine until September 11th (2001). She got very excited and wound up about 9/11, couldn't get enough news about it as she knew it was going to have a huge impact on the world. About a month later she went high even though she was still on medication at the time (she had been on the same medication for about three years at that point). She drove out the dual carriageway out of Limerick on the wrong side of the road one Sunday morning at about eight o'clock, and she crashed into a man. The police were called but Ms O'Shea said she didn't feel as if she had done anything wrong; she didn't feel any guilt, she just did it because she felt like doing it – and that's what she told the Gardaí when they came as well.

She was brought to Henry Street Garda Station in Limerick, where she was questioned and then locked in a cell on her own. A doctor was brought in – as she was high, she said she sat up on the desk and said to him 'Now doctor, do you really think there's anything wrong with me?', so he left very fast. He thought there was nothing wrong with her, so she got away with it, she said that this was much to her own disadvantage. She was eventually brought to Court in Limerick, and she shouted all sorts of obscenities at the Judge – she told him to leave his wife, that he should move out of his big house up the country and move into the inner city and get to know the people in the inner city, and that he knew nothing about the poverty there. So she said the Judge was very annoyed with her, obviously, and she was held in contempt of Court and brought to Limerick Prison. Now that was where she had worked so she knew a lot of the faces there and they were very good to her.

Again, she was locked in a cell and kept in solitary confinement for about a week. Another doctor kept coming in to ask her to take her medication, but she would not do it and she was getting higher and higher all the time. Ms O'Shea said that eventually they decided to cart her off to Dundrum – the institution for the criminally insane – and she was there for a week before being brought back down to Limerick Prison again for Court the following day. She had not been eating at all at this time, only drinking orange juice and water, but that night it struck her (maybe because the medication was kicking in) that she had three children so she asked herself what it must be like for them to have a mother in prison. So she decided to eat something to ground herself, so she had a good meal and went to Court the following day. Her brother was waiting for her in the Court and he had arranged a solicitor for her, but she was very nervous about what might happen, whether she would get a sentence and end up back in prison again. Thankfully, the Judge released her into the care of the mental health services, so she was brought back into Ennis hospital again.

Ms O'Shea said she was in Ennis hospital for two weeks after that, and because her regular psychiatrist was there she persuaded him to give her a

low dose of medication again. So she came home and almost immediately she went high again. One Saturday morning she went into town and stopped all the traffic in the market – one woman actually came over to her and thanked her for stopping the traffic because her business was improving, she even gave Ms O'Shea a little cuddly teddy to thank her.

Between the first and second breakdown, Ms O'Shea said she had been assigned a very nice social worker. The social worker was English and she introduced Ms O'Shea to W.R.A.P – wellness recovery action plan – developed by Mary Ellen Copeland in America. With the social worker's help, Ms O'Shea drew up a Plan for herself and on it she put the names of the two psychiatric nurses in Ennis, her ex-husband's name and telephone number, and her next-door neighbour's, who was absolutely brilliant to her. The Plan was to cover what she wanted to happen if she ever went high again or got sick. Ms O'Shea said that the funny thing about it was that the day she was at the market her neighbour was supposed to have been keeping an eye on her, but when Ms O'Shea arrived home in the squad car the neighbour saw nothing wrong with it – she asked Ms O'Shea if she was all right and Ms O'Shea said she was fine, that she'd just been in town for the morning.

Ms O'Shea said she had done some crazy things, but they were all part of the illness. She was taken back into hospital again, and while she was there she decided that she would go on an injection, she felt she could not run the risk of behaving that way again, mainly for her children's sake. It was a monthly injection, a very small dose, but eventually she went high again. This time, the Wellness Recovery Action Plan came into play; Ms O'Shea explained that her next-door neighbour rang the Community Psychiatric Nurse, and she came out straight away and talked to Ms O'Shea. After discussing how Ms O'Shea had been behaving, the Nurse suggested re-evaluating her medication, and so the injection became fortnightly rather than monthly. The side effects were very pronounced however, so the dosage was re-evaluated again and Ms O'Shea then began receiving the injection every three weeks, a dose she was still on at the time of the presentation. She said she still gets side effects, and she would really love not to be on medication at all, but she is not sure if this would ever be possible in her lifetime.

Ms O'Shea said that when she was married, she and husband were very comfortably off, but in the last few years of her marriage she was not happy. When she and husband broke up, she left the family home to her husband and eventually managed to buy her own house only two miles from the family home. This meant that her children were able to come and go between the two houses – they lived with their father but went to Ms O'Shea for dinner or just to visit after school. Ms O'Shea said that she spent about a year in rehab, as she felt she needed some structure to her day, and while there she decided she needed to work again. She could not really drive a bus again – not after her experience on the dual carriageway – so she decided to try cleaning and that is what she has been doing ever since.

Looking at what is needed for mental health services, Ms O'Shea said she believes a gendered approach is needed. She also said that a holistic

response is needed, to look at all needs – for example, parenting issues, lost libido, etc. She found that there was no emphasis on what she was going to do when she got out of hospital, what she could do about work for example. Ms O’Shea believes that the focus should be on recovery rather than on maintenance – like the WRAP plan. She said she would have been back in hospital again without the WRAP plan, and she said the important thing to remember there was that her social worker was English, and the Plan came from the English model of Community Health. Ms O’Shea also said there should be more community care, and more social workers, home support, family support, information and counselling. All services and supports need to be offered, because when people are unwell and vulnerable they may not be able to ask for services/help so they need to be told about services/supports available.

In conclusion, Ms O’Shea said that today she is in recovery – she is not fully over what she had gone through, and as long as she is on medication she will not regard herself as being fully recovered. She is a caregiver to her children – her eldest is in college and works part-time, and the two other children are doing the Leaving Certificate.

Ms O’Shea herself is employed and in a relationship with a supportive partner, and she is involved in the Women’s Network so she is supporting other people as well.

She is here today.

Women and Mental Health Services: The Work of the Mental Health Commission

Ms Bríd Clarke, Chief Executive Officer, Mental Health Commission

I wish to thank the Women's Health Council for the invitation to speak at today's conference on Women's Mental Health. We all know that in discussions about the health services in Ireland, mental health services rarely feature - it is the forgotten service despite international evidence indicating the universality of mental illness. To quote from the World Health Organisation in their report "*Mental Health: New Understanding, New Hope*", (2001)

"Mental disorders are not the exclusive preserve of any special group; they are truly universal. Mental and behavioural disorders are found in people of all regions, all countries and all societies. They are present in women and men at all stages of the life course. They are present among the rich and poor, and among people living in urban and rural areas. The notion that mental disorders are problems of industrialised and relatively richer parts of the world is simply wrong. The belief that rural communities, relatively unaffected by the fast pace of modern life, have no mental disorders is also incorrect. ..."

"Surveys conducted in developed as well as developing countries have shown that, during their entire lifetime, more than 25% of individuals develop one or more mental or behavioural disorders."

Today's conference provides an ideal opportunity for increasing understanding and awareness of mental illness and mental health services.

The Mental Health Act 2001 is the most important legislative provision introduced in Ireland in the last 60 years in the mental health area. Significantly it brings Irish legislation into conformity with the European Convention on Human Rights and Fundamental Freedoms. Sections 1-5, 7 and 31-55 (Part 3) of the Mental Health Act 2001 were commenced in April 2002. These sections deal primarily with the establishment of the Commission, its functions and responsibilities and the appointment and duties of the Inspectorate of Mental Health Services.

The Commission consists of 13 members, representing key groups within the mental health services. Significantly the Commission membership includes two service users. This is an important inclusion and this is an area I will be returning to later.

The Mental Health Commission is an independent statutory agency. The Mental Health Act specifies the mandate of the Commission as follows:

- To promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services

and

- to take all reasonable steps to protect the interests of persons detained in approved centres.

It is important also to emphasise that the Mental Health Commission covers the broad spectrum of mental health services - child and adolescent services, general adult services, services for later life, forensic mental health services and mental health services for people with an intellectual disability.

A number of principles underpin the provisions of the Mental Health Act 2001 and these are of key relevance when looking at service provision. Section 4 of the Mental Health Act 2001 states that the best interests of the person shall be the principal consideration in all decisions made under the Act. This means that while having due regard for the interests of other persons who may be at risk of serious harm, one's actions and decisions at all times should respect the right of the service user to dignity, bodily integrity, privacy and autonomy. This principle is of fundamental importance in shaping policies and service provision within the mental health services. The Act also places on a statutory footing, quality and best practice, rights to information and procedures relating to consent.

The Mental Health Commission published its Strategic Plan for 2004-2005 in March 2004. We identified six strategic priorities. These include:

- To promote and implement best standards of care within the mental health services.
- To promote and protect the rights and welfare of persons availing of mental health services, as defined in the Mental Health Act 2001.
- To promote and enhance knowledge and research on mental health services and treatment interventions.
- To increase public awareness and interest in mental health services.

The work and activities of the Mental Health Commission in support of these strategic priorities reflect a number of the issues raised in the position paper of the Women's Health Council on Women's Mental Health. I now intend to focus on a number of these in greater detail.

Involuntary Admissions

One of the aspects of the Mental Health Act, 2001 which has probably received the greatest level of publicity is that the Act introduces new (and long overdue) procedures to protect the rights of people admitted involuntarily to our psychiatric hospitals and units. The Act introduces an independent review system for those admitted involuntarily which encompasses a review by a three-person mental health tribunal, an independent medical examination and the right to legal aid. The Act also specifies the service user's right to information and sets standards for consent to treatment. The initial review by the mental health tribunal must take place within 21 days of the admission and then at specified intervals thereafter.

In 2003, there were 23,031 admissions to psychiatric hospitals and units, representing a rate of 760.4 per 100,000-population aged 16 and over. Of these, almost 11% (2,435) were involuntary, representing a rate of 80.4 per 100,000 population. Overall, more men than women were admitted involuntarily to hospital and this has been the trend for a number of years.

In 2003 the breakdown was:

	No.	Percentage	Rate
Male	1,378	11.8% of all admissions were involuntary	92.4 per 100,000
Female	1,057	9.3% of all admissions were involuntary	68.7 per 100,000

Research on involuntary admission rates under the Mental Health Act 1983 (England and Wales) shows that in the younger age group (up to 40 years) rates of detention are higher for males than females but this is reversed (albeit slightly) in the older age group largely due it is considered to the lower life expectancy of men.

Work is continuing on having all the systems and structures in place as soon as possible to facilitate the introduction of these fundamental civil safeguards and protections for those admitted involuntarily. This includes the appointment of members to the mental health tribunals, the preparation of an extensive Reference Guide on the Mental Health Act 2001, the publication of leaflets and booklets and the roll-out of training programmes. The Commission is committed to ensuring that only those who require treatment on an involuntary basis are so admitted and that such admissions are for the minimum period necessary. The new protections in the Mental Health Act, 2001 will facilitate the achievement of these objectives. Valuable information will also be available with the introduction of these procedures, in relation to involuntary admissions which will increase our understanding and enhance treatment outcomes. An audit of involuntary admissions in 2002 conducted by the Mental Health Commission and the Health Research Board showed that 74% of the people admitted involuntarily had had previous contact with

the mental health services. This raises challenges for us in how services are delivered and how we can intervene to reduce the number of involuntary admissions.

Achieving Quality Person-Centred Mental Health Care

We now know that mental illnesses affect women and men differently - some mental illnesses are more common in women and the presentation of the illnesses varies. Treatment outcomes also vary. Research studies are identifying the risk and protective factors for mental health for women and how to improve the treatment outcomes. We know that women are more likely to experience low social status, isolation and poverty. Frequently women have multiple roles as members of the workforce and assuming major responsibility for childcare and caring for other family members. All these factors can have an impact on women's mental health. There is an increasing body of literature on women's mental health. The National Institute of Mental Health (England and Wales) provides a very useful overview of research into mental illness in women in a publication called "*Women hold up half the sky*". Dr. Dora Kohen, a consultant psychiatrist in London, has written extensively on this area. The editorial of the current issue of the American Journal of Psychiatry is titled "*Vulnerability to mental illness: gender makes a difference, so does providing good psychiatric care*". These studies and papers point to the need for gender sensitivity and gender awareness in the planning and delivery of mental health services.

Issues that have been highlighted in these studies on women's mental health and services include:

- (i) Ensuring safety, privacy and dignity in mental health units. Mental health care in Ireland is generally provided in mixed sex environments. Access to women-only services and activities is very limited. Some writers advocate the development of single-sex units and single sex service provision. However others have emphasised women's wish for choice and how we can ensure their safety and dignity. Currently in Ireland almost 50% of our acute admission units are within general hospitals and the intention is to phase out the usage of psychiatric hospitals for admissions. We are also seeing the development of crisis houses and respite facilities, day centres and day hospitals. In residential units, bedroom and bathroom facilities are provided on a single-sex basis, but living / leisure space is generally mixed. The needs of male and female in-patients may be different. Providing a safe environment is particularly important in settings where women may be in a small minority e.g. secure care. Does the design of units protect individuals' safety, privacy and dignity? Facilities should be designed to promote flexibility in the use of accommodation e.g. day rooms designated with women only access for periods of time. Providing information about the facilities in advance of admission can also help to allay concern and unease. Assigning responsibility for women's safety, privacy and dignity to a senior officer in residential

services has also been identified as an effective strategy. This is an area that will be addressed further by the Mental Health Commission.

(ii) Choice.

Studies both here and abroad have clearly outlined the demand for choice in treatment interventions and therapists. The Mental Health Commission launched the outcome of stakeholder consultation on quality in mental health services (Quality in Mental Health - Your Views) on 22nd February 2005. This is the first-ever joint stakeholder consultation on mental health services in Ireland involving service users, carers and families and service providers. The report describes the outcome of the consultation process conducted between May-August 2004 which involved eight consultation workshops, two focus groups (Dublin and Cork) and 239 written submissions from stakeholders. Eight key themes were identified. The first theme identified *“the provision of a holistic, seamless service and the full continuum of care, provided by a multidisciplinary team as an essential factor of a quality mental health service.”* Stakeholders called for choice in a range of interventions, community-based services and a continuum of support. Individualised care planning was identified by all as one of the key aspects of a quality mental health service.

(iii) Empowerment and recovery.

Mental health services, until recently, would have been viewed as paternalistic and protective in their approach. Service users are now insisting that they and the service providers work together in partnership which will maximise the sharing of information and autonomy. Women have been to the forefront in expressing their wish to be listened to, be involved, be treated as a partner in their treatment.

Historically people with a mental illness were not expected to recover. However during the last 15 years or so, people, especially service users, are talking about recovery. The recovery model in mental health services emphasises personal growth, building self-esteem, autonomy, empowerment and having a meaningful role in society.

Whereas initially the recovery model was promoted primarily by non-statutory groups, the model has been adopted as public policy in a number of countries. For example, the US New Freedom Commission on Mental Health places this concept of recovery centre stage within a new transformed mental health care system. The New Zealand government in their *“Blueprint for Mental Health Services in New Zealand”* published in 1998 promoted the recovery model and have subsequently published further policy and training documents on recovery competencies. Services users in New Zealand with the assistance of the New Zealand Mental Health Commission have recently published *“Our Lives in 2014 - A Recovery Vision from People*

with Experience of Mental Illness". They describe leading their own recovery supported by services through

- Experiencing hope and optimism
- Making sense of our experience
- Accessing and using information
- Managing our mental health
- Knowing how to get the best service
- Advocating for our rights and inclusion at all life stages
- Belonging to the culture and lifestyles we identify with
- Fulfilling our goals, roles and responsibilities
- Maintaining our personal relationships
- Contributing to healthy whānau.

The Mental Health Commission established a committee in February 2004 to prepare a discussion paper on "*Concepts of Recovery and Service Implications*". This paper will issue in the next few months to all the stakeholders and interested parties, seeking their views and comments. We hope this will contribute to the discussion on the recovery model within the Irish mental health services.

Carers and Families

Carers and families have a pivotal role both in general health care and mental health care - the "*invisible healthcare system*". Caring can impact on overall family functioning, on family finances and relationships. An additional factor in caring for a family member with a mental illness is the stigma and discrimination still unfortunately associated with mental illness.

Numerous studies over the last decade have provided estimates of the overall numbers of carers in Ireland. The 2002 census, for the first time, included a question on caring:-

"Do you provide regular, unpaid personal help for a friend or family member with a long-term illness, health problem or disability?" Respondents were also asked to indicate the number of hours involved per week ranging from 1-14 hours to 43 hours or more. The census reported a prevalence rate of 4.8% of the adult population aged 15 and over. Other studies, have given a prevalence rate of 5-6%. Based on 2002 census figures, 4.8% of the adults overall represents 148,754 people. (Source: Caring, Working on Public Policy, Cullen, Delaney and Duff, Work Research Centre, Report for the Equality Authority, 2004).

Women are much more likely to be carers than men. Earlier studies would have indicated that about three quarters of all carers were women. The 2002 census study found that 6 out of 10 carers were women. (European figures indicate that about two-thirds of carers are women). However it is important to note that women comprise 64.7% of carers providing 15 or more hours, and 66.7% of those providing 43 hours or more.

We do not have information here in Ireland about the numbers and extent of caring for those with a mental health problem. A study conducted by the Institute of Psychiatry London (1998) found that 24 mothers (73%) who were primary care givers were living with the person with schizophrenia compared to 2 fathers (29%). Over half the mother carers were also working outside the home. Women reported on the negative affects of this on their relationships, household matters, employment, finances and social life.

In the previously mentioned report of the Mental Health Commission “*Quality in Mental Health Care - Your Views*,” families, parents and carers were asked their views on a quality mental health service. Families and carers highlighted the provision of information and advice as their most pressing need. They stated that they needed factual information on what services are available, how the services work and how to access them, especially in a crisis. Carers and families also indicated that they felt they should be part of the team, be involved, work in partnership. They also believe families need support, counselling and therapy to help them deal with the additional pressures. And, as with all people using the mental health services, families and carers expect understanding, empathy and respect.

One of the dilemmas in working in partnership with carers and families is balancing the right of the service user to confidentiality and yet ensuring that the carer is involved and informed. This aspect requires further consideration and examination. We need to differentiate between personal private information which is not relevant to the treatment programme and information which directly relates to the treatment. Access to different members of the multidisciplinary team for the service user and for the family can facilitate communication. Most importantly however, information, if it is to be shared, should be exchanged in an open, planned manner, based on informed consent.

Research

The World Health Organisation in their 2001 Report “*Mental Health: New Understanding, New Hope*” stated:

“Although knowledge of mental and behavioural disorders has increased over the years, there still remain many unknown variables which contribute to the development of mental disorders, their course and their effective treatment. Alliances between public health agencies and research institutions in different countries will facilitate the generation of knowledge to help in understanding better the epidemiology of mental disorders, and the efficacy, effectiveness and cost-effectiveness of treatments, services and policies”.

The Mental Health Commission has recognised the importance of high-quality research in mental health services by highlighting the promotion and enhancement of knowledge and research on mental health services and treatment interventions as one of its key strategic priorities. Health research

in general in Ireland is limited and it is widely acknowledged that the research base in mental health is small and underdeveloped. Whereas research from other countries can provide invaluable insights and information, we need our own body of knowledge which takes account of the social and cultural factors in Ireland and the configuration of service provision. The Women's Health Council paper acknowledges the dearth of research in mental health services in Ireland.

To address this deficit, the Mental Health Commission has prepared a research strategy which will be published next month. The Mental Health Commission, in particular, aims to promote service based research, research which is accessible and relevant to those working in the mental health services, involves users and is incorporated into practice. As part of its research strategy, the Mental Health Commission will be developing an Irish Mental Health Research Network and Database which will facilitate communication and sharing of information. Currently, people tend to conduct research projects within a particular service and the knowledge gained is not disseminated throughout the service.

The Commission has funded four research projects to date. These are

- An audit of the pathway to involuntary admission (MHC and HRB)
- Users views of publicly funded mental health services (MHC and UCC)
- Study on community residences (MHC and HRB)
- Economic Research on Mental Health Care in Ireland (MHC and UCC)

We plan to develop an ongoing programme of research in mental health services in consultation with stakeholders.

This is a challenging time within mental health services as we introduce new legislation. It is also an exciting and stimulating period for mental health. Although mental health services are the forgotten aspect of health care, we have noticed and welcomed an increased interest in mental health services during the last two years and the Mental Health Commission is committed to pushing mental health care to the forefront.

Many factors impact on the prevalence of mental illness, the service response and treatment outcomes. These include gender, age, culture and race, social class, inequalities and previous life experiences. Mental health policy and provision which is user based ensures these factors are addressed. This means involving the service user at all levels within the service from individual care planning to the planning and delivery of mental health services. Although we have seen an increase in research studies which are focused on service users' views (including the studies commissioned by the Mental Health Commission) we have not seen as much progress in relation to service user involvement and participation in service planning and delivery. The Commission for Health Improvement (now called the Healthcare Commission) in its last review of mental health trusts advocated the involvement of service

users. In their view, their involvement is even more crucial in mental health services than in other areas of health services, as people can be compelled to use the service and also the actual experience of the service is critical to recovery. The stigma and discrimination associated with mental health is a powerful reason for advocating the involvement of service users. Mental health services could be to the forefront in developing models of service user involvement which could then be introduced in other health care services. Everyone deserves the best of services. Listening and working with and empowering service users is key to achieving this objective - an objective fully and wholeheartedly endorsed by the Mental Health Commission.

Panel: Ms Mary O’Shea, Ms Bríd Clarke, Ms Alessandra Fantini, Ms M. Claire O’Connor (Chair)

- Participant asked Ms O’Shea about the impact of her illness on her children, and asked what sort of help she would have wanted both for herself and for her children around support and coping mechanisms. He also asked about the possible role of education in teaching people about mental health.

Ms O’Shea said that so far her children seem fine, they have not presented with any difficulties. Her two sons are very involved in sport and her daughter has very good friends. She said she would be concerned if her daughter has children, because it was after Ms O’Shea herself had children that she presented first with mental health difficulties and both her sisters also had mental health difficulties after they had their children as well. Everything has been fine so far though. In terms of services and supports, Ms O’Shea agreed that education would be of help. She said that her ex-husband was very supportive when she got sick so she was able to stay involved in her children’s lives, but he got no support from the health services himself.

- Another participant asked about Ms O’Shea’s experience of stigma and how she coped with it.

Ms O’Shea said she lives in a small rural community and that meant that she went through her illness in public. She said in spite of that she did not feel that she had been stigmatised – people still say hello to her. Her old neighbours do not salute her when they see her in the car but other than that she did not feel she had been stigmatised. She said she does not give it much thought.

- Participant said that the Mental Health Commission has been a very positive development, but asked about the use of the term ‘Tribunal’ to describe an appeals panel as he felt it might be stigmatising. Secondly, he asked about Ms Clarke’s views about having a service user sitting on the Appeals Panel.

Ms Clarke said that the Commission is bound by the legislation – the Mental Health Act was a long time in coming and the word ‘tribunal’ did not have the connotations it currently has in this country when it was originally used in the legislation. ‘Tribunal’ is the word used in most of the English speaking jurisdictions, however. The Commission is conscious, however, that service users may be apprehensive about Tribunals – they think it will be like the ones going on in Dublin Castle and that people are going to be subjected to cross-examination and public criticism. In their own language, the Commission would tend to use the word ‘review’ and this is the word used in the literature and the guidelines going out but this is a legal context so therefore they do still have to be called Tribunals. Interestingly, the Act contains two provisions: one is that within eighteen months of the Tribunals being up and running they have to present a report to the Minister on how they have worked, something the Commission sees as a very good review mechanism. Secondly, the whole Act is subject to a very detailed report to the Minister within five years of its

commencement. In relation to service users being involved in the Mental Health Tribunals, Ms Clarke said that she was absolutely in favour. Under the terms laid down in the Act, the Chair has to have a legal qualification, there has to be a Consultant Psychiatrist, so the group could also include service users and for the lay person it would be preferable to have someone with an interest in the mental health services. Ms Clarke said she is fairly confident that there are service users involved in Irish Tribunals. Around involving service users or people with mental health difficulties, Ms Clarke expressed a concern about how people are identified, labelled or assigned to categories. She said it would be important to consider how this is to be done and why we are doing it.

- Participant expressed her preference to have a peer advocate on the Tribunal, particularly for people with other disabilities or members of minority groups. She asked if it would be possible for the Commission to hold a public review to change recommendations?

Ms Clarke said that peer advocacy is integral to the work done around the Mental Health Tribunals and the services being developed. The Commission has quite close links with different peer support groups and also with the Irish Advocacy Network, who see themselves as having a strong role in preparing service users for the Tribunals, and they have already had talks about how they would fit into the whole process. Ms Clarke said she strongly believes that the Commission is not medically dominated, she had hoped that her presentation would put across the importance it places on the social model, emphasising the importance of choice and that of listening to service users' views (particularly regarding the recovery model, which has previously been emphasised by users).

- Participant asked about services for people with learning difficulties who experience mental health issues, especially those in long-term residential/institutional environments. Is there a multi-agency approach to service delivery or is it still very ad hoc?

Ms Clarke acknowledged that some aspects of the services in Ireland, including institutional services for physical and learning disabilities, are developed in an ad hoc manner. One of the things that must be emphasised at all stages is that the situation is very different for someone who is in a long-term residential unit than for someone in a unit for a short period of time or who is living at home, so there is a need for a very definite response.

Ms O'Connor mentioned a report published by the NDA in 2003¹⁵, which focused on people with intellectual disabilities accessing mental health services. It was prepared in the context of challenging behaviours but in fact what it highlighted was that clinical psychiatrists were engaged by service providers not health boards. This meant that if a person was not availing of a service provider then he/she found difficulty accessing that service. The report

¹⁵ National Disability Authority (2003). *Review of Access to Mental Health Services for People with Intellectual Disabilities*. Dublin: National Disability Authority. <http://www.nda.ie/>

is available from the NDA, it has fed into their own Mental Health Advisory Committee deliberations and the working of the Expert Group on Mental Health so the problem has been identified and the solutions are there in the recommendations.

- Participant asked if there was any acknowledgement or work carried out looking at the effect impact of long-term institutional care on mental health?

Ms Clarke said she was not aware of any specific work that has been done in Ireland on the area, but said that the impact or possible impact institutional care can have on a person's mental health and well-being is well acknowledged, both in Ireland and in other countries. Ms Clarke said it was still an area that needs greater attention and focus, however.

Ms O'Connor thought it was worth mentioning that when the NDA first started its research agenda it went on a national consultation round to establish with people with disabilities what their research priorities were. The NDA also consolidated the research that had been done from 1996 to 2001 into one database that it now available on its website. It then tried to align the research topics with the strategic direction of the NDA. The NDA has been trying to have bilateral meetings with every other agency that has a research budget – for example, with the National Children's Strategy, the NDA is attempting to make sure that a cohort of children with disabilities is included in its longitudinal strategy.

- Participant asked if people being transferred between prison and the Central Mental Hospital would also have access to Mental Health Tribunals?

Ms Clarke said that people could be placed in the Central Mental Hospital on a number of grounds; those transferred from their local psychiatric or mental health service under section 208 of the 1945 Mental Health Act account for roughly a quarter to a third of people in the Central Mental Hospital). These people would be covered by the Mental Health Tribunal under the new Act, which specifies that there has to be a specific mental health tribunal hearing in relation to a transfer to the Central Mental Hospital and gives the right of appeal to the Circuit Court. People who are transferred under prison regulations are not covered by the Mental Health Tribunals under the Mental Health Act, however. This situation may change, depending on the final outcome of the Criminal Law Insanity Bill (a title that a lot of people have concerns about). At the moment that Bill does not cover the transfer of prisoners, but discussions are ongoing and representations have been made on that point, both by the Mental Health Commission and probably also by the NDA. The Bill has also proposed the establishment of their own tribunals, possibly called Mental Health Review Tribunals.

- Participant made the point that services also need to be culturally appropriate – ethnic minorities such as Travellers have very different health needs, and their access to all health services is very difficult.

The racism and discrimination that happens within health services needs to be acknowledged, and we need to look at the impact that can have on people and on their mental health. Regarding the lack of data on mental health, this is even more the case for Travellers, so ethnic identifier questions are hugely important to produce more statistics on what is happening in order to provide that are actually needed. A study done in 1997 showed that 34% of Traveller women suffer from depression compared to 9% of the general population, so without ethnic identifiers its very hard to tell what the actual needs are.

- Participant asked where the panel feel the resources for research into the needs of women and what works for women may be or should be accessed?

Ms Fantini said that every relevant organisation should have a research budget, and the Women's Health Council are very glad to hear that the Mental Health Commission is taking such a strong role in relation to research. In addition, research also needs to be promoted at Department level as well as at HSE level; each Directorate should have its own research budget as all the different levels and sectors need to be able to address the specific needs of the people that use them and gender should sit in all these different areas. The role of the Health Research Board should also be mentioned. As everyone has pointed out, without the data it is very hard to improve services and therefore it is very hard to improve outcomes.

- Participant mentioned the need for an integrated approach to research – not just focusing at the health service alone. He asked what the Women's Health Council is going to do in terms of following the report through?

Ms Fantini said that the purpose of the report was to set out the position of the Women's Health Council, and she hopes by helping the dissemination of the report, through the present conference, the post and of course having the report on the website, that the Council's position will become more well-known. Apart from that the Council's intentions are to continue to liaise with other relevant agencies and see that they and others will take the message on board.

Ms O'Connor mentioned that the NESF had a recent conference on evidence-based policy making, and the student's hall in UCD was packed out with key players who are accepting the argument that you cannot make your case unless you have your quantitative and qualitative research. She suggested that the tone of the debate is changing from 'put up the political argument then find the evidence' to now having a context in which arguments are being built. There is a big onus on all the agencies that have research budgets to collaborate on the dissemination; to join up the arguments and to work on equally effective dissemination of strategies.

Geraldine Luddy, Director of the Women's Health Council, also added that the report will also be sent to the Expert Group on Mental Health and that the Council hopes to do further work with Bríd Clarke and the Mental Health Commission. She suggested that the task for the present time is to integrate all the research currently available and to work together in creating and developing policy based on the information we have.

- Participant made reference to the need for people with lived experience to sit on boards and so on, and drew attention to the need to pay people for their expertise in terms of this type of representation. She said people need resources, dignity and respect so that they can sit at the table and feel equal. She asked the NDA and the Commission what they are doing in this regard?

Ms O'Connor made reference to the NDA's participation guidelines titled *Ask Me* which recommended that the best practice for consultation was that consultees be paid. Unfortunately, the Department of Finance is not structured to be able to follow through on that so at the moment it is not possible for the NDA to pay consultees anything other than out of pocket expenses. It is a very contentious issue and it is a point that has been made very forcibly at the NDA's Mental Health Advisory Committee and on the various consultations the NDA has been involved in, and Ms O'Connor said she personally had exhausted all avenues as she could seeking clarification on it so the issue is to keep on making the point.

Ms Clarke suggested that a model worth looking at and that could be developed is the Irish Advocacy Network. People are still involved in it in a non-paid volunteering way but there has been an increase in the number of people who are paid for their involvement and employment. So there are ways, rather than individual payments, but rather through organisations that have been set up by people who have had the personal experience and run by people with the personal experience. The Club House would be another model within the mental health area.

Closing Remarks

Prof. Joyce O'Connor, Chair, Expert Group on Mental Health Policy

Prof O'Connor opened by saying she was very pleased to be at the conference and was very interested to hear the discussion going on. She congratulated everybody involved in the study *Women's Mental Health; Promoting a Gendered Approach to Policy and Service Provision*. She said the report clearly outlines the key concerns and issues discussed today. As Chair of the Expert Group on Mental Health Policy, she said that they were very pleased to get the report and will be considering it in the context of their work, and looking to integrate it in the work of the Group.

The brief of the Expert Group is very clear; they have been asked to look at a policy framework for the next ten years; to recommend how services can best be organised and delivered; and to indicate the potential cost of the recommendations. Listening to the discussion at the conference, Prof O'Connor said she could see that that was a central concern of the participants, of all users of mental health services, and particularly of women as they are the group being focused upon at the conference. Prof O'Connor said the Expert Group is 'keeping its eye on the horizon but its feet on the ground', by trying to cost the policy framework.

The Expert Group on Mental Health was established in August 2003, and it consists of eighteen widely experienced people. Members are drawn from a wide range of professions represented on the Expert Group – medical, nursing, legal, paramedical, voluntary bodies, and service users – and all have agreed that there is no point taking on a policy framework unless the issues can be addressed and acted upon. The Expert Group is currently mid-way through its work, so it is still a work in progress, Prof O'Connor said. The Group is on a tight deadline and anticipates that its work will be completed by the end of the summer 2005.

The essence of the Group's vision is a mental health service that everyone can use and be proud of. Members would like to build a mental health service that recognises the universality of emotional distress; that informs, supports and empowers a person, her family and community to achieve her full health potential; a mental health service that is there when people need it; a system that is fair, that treats people with respect and dignity, and protects people and their human rights; a mental health service that works in meaningful partnership, that will let users have their say, listen to them and ensure that their views are taken into account. The mental health service should be one that supports and empowers service providers to maximise the use of their expertise. Finally, it should be a mental health service that is visible, competent, progressive, and is fully supported and accepted by everyone.

Although this is an extensive vision, Prof O'Connor said it is needed. She said she believed that the time is right and that the ground is now being set –

through the work of the Commission, discussion in the media of these issues – for a strong vision and policy that will include everybody, ensuring that inclusion is not just rhetoric. The Expert Group conducted a very strong consultation process in 2004, consisting of over 150 written submissions, over 3000 postal questionnaires, two public consultation days (one in Dublin and one in Limerick), and one-to-one interviews with users of adult services. The consultation process and the user survey have been published – *Speaking Your Mind* is the title of the report on the views of those involved in the service, and the other is *What We Heard; The Views of One-to-One Consultation with Service Users in the Adult Mental Health Service*¹⁶. Prof O'Connor said that the clear message from the consultation process was that people want services that are person-centred, accessible and of a high standard. That message was loud and clear no matter whom you were talking to, and as she mentioned before, Prof O'Connor said she felt the time was right to address that message in a clear and systematic way.

Part of the work of the Expert Group has been to involve as many people as they could – they have over two hundred and fifty people working on the Advisory Sub-Groups, under a whole range of areas. There are twenty sub-groups in all, including groups established to examine mental health promotion; primary care; child and adolescent; adult mental health services; forensic services; manpower, training and research; suicide; later-life mental health services; services for people with intellectual disability; services for homeless people; management and organisation; and research and information. The establishment of the Sub-Groups was a way of involving the unbelievable expertise and experience available in Ireland and of hearing the views of people from a range of fields. The work of the Sub-Groups has been continuing apace and Prof O'Connor said she believed it has been very useful, as it has ensured that the range of issues out there can be brought forward.

In working on evolving a model of mental health service delivery, the Expert Group has suggested that the service should be person-centred, with reference to the identity and needs of particular groups. It should be delivered at different levels of care according to need, and integrated with other services so that for example a person's housing, transport, education, social welfare needs, etc., would also be taken into account. Echoing the approach of the Mental Health Care Commission, the service should be delivered by a Community Mental Health Care Team, with a range of expertise and services, and there should be user participation at every level of the service – feedback to improve the service and thereby better meet the needs of users. Prof O'Connor said that constant feedback, undertaken in a consistent manner, is the best way to ensure that the service is being properly provided. Care plans appropriate to each level of intervention should be developed, and the service should be linked to the primary care/natural supports systems already available to users. Finally, the mental health service should be geared towards recovery and the meaningful reintegration of the user within their own community.

¹⁶ Available on the Expert Group on Mental Health Policy website at <http://www.mentalhealthpolicy.ie/consultation/>

Prof O'Connor said that Minister Tim O'Malley, who has responsibility for Mental Health, has been very supportive of the work of the Expert Group and that he also feels that the time is ripe for this review. The Expert Group will be drawing on the work of the Advisory Sub-Groups and the reports from the consultation process in compiling its final report. This work is currently on target and they hope to publish the final report later in 2005.

In conclusion, Prof O'Connor thanked the Women's Health Council and the National Disability Authority once again for the invitation to address the conference. She again congratulated the Women's Health Council on the production of its report on 'Women's Mental Health', and said that it would form another input of expertise into the work of the Expert Group.

Close

Biographies

Ms. Bríd Clarke, Chief Executive Officer, Mental Health Commission

Ms. Bríd Clarke is a former psychiatric social worker. She worked in the adult mental health services and child and adolescent mental health services in Dublin. Subsequently, Bríd worked in the former Eastern Health Board initially as Director of Child Care and Family Services and then as Programme Manager for services for children and families including child and adolescents mental health services. In 2000, Bríd moved to the South Western Area Health Board as Assistant Chief Executive Officer with overall management responsibility for services including mental health, older people and community services. Bríd was appointed as the first Chief Executive Officer of the Mental Health Commission in December 2002.

Ms. Alessandra Fantini, Policy Officer, Women's Health Council

Alessandra Fantini has worked and conducted research in a number of areas related to women's health including gender-based violence, crisis pregnancy and single parenthood, and opiate addiction and recovery. Since joining the Council in April 2004, Alessandra has been developing the Council's position on the health implications for women of the government legislative programme, and working on mental health, and maternal and child health projects. She is a graduate of Edinburgh University and Trinity College Dublin, with Master's degrees in Social Anthropology and in Applied Social Research. Alessandra previously worked as a research consultant for One Family and as a project coordinator for the Rape Crisis Network Ireland.

Prof. Cecily Kelleher, Chair, The Women's Health Council.

Cecily Kelleher, Chair of The Women's Health Council, is Professor of Public Health Medicine and Epidemiology, University College Dublin and Honorary Consultant and Head of Department of Preventive Medicine, St Vincent's University Hospital. Previously, she was the foundation Chair of Health Promotion at NUI Galway, where she developed an inter-disciplinary research programme that included the direction of Ireland's first ever national lifestyle survey, SLÁN. She has contributed actively to public policy documents and national committees and is a member of the National Council for Bioethics at the Royal Irish Academy. Her interests are in the contribution of social factors to the development of chronic ill-health, particularly cardiovascular disease.

Ms. Angela Kerins, Chair, National Disability Authority

Angela is Chairperson of the National Disability Authority, the state authority, established under the aegis of the Department of Justice, Equality and Law Reform, to act as the central national body for disability policy, programmes and standards in service delivery.

Angela was Chairperson of the National Co-ordinating Committee of European Year of People with Disabilities in Ireland and oversaw the many activities that took place in Ireland to celebrate this year. She was also a patron of the 2003 Special Olympics World Summer Games. Angela chairs the Disability Legislation Consultation Group, established by government to consult with the sector on the content of new disability legislation. The DLCCG is made up of the umbrella bodies representing the views of

over 507 disability organisations and many thousands of people with disabilities in Ireland.

Angela is employed as Director of Group Development and Public Affairs of the Rehab Group and Chief Executive, RehabCare. RehabCare was established in 1996 and now provides services to approximately 2,000 clients, employing over 700 staff. She has many years' experience as a senior manager of health and social care services, both in Ireland and overseas and is a member of the boards of a number of voluntary bodies in Ireland and the UK.

Angela has served on a number of state boards, including FÁS International, the National Council for the Elderly and the National Rehabilitation Board as well as the Establishment Group, which was responsible for the implementation of the government's policy of mainstreaming of services for people with disabilities. She has also served on a number of review and advisory bodies of the Department of Health and was recently appointed to the Broadcasting Commission of Ireland. In 2003 Angela was awarded an honorary Doctorate of Laws (LLD) by the National University of Ireland, University College Dublin, in recognition of her work in the disability sector in Ireland.

Prof. Joyce O'Connor, Chair, Expert Group on Mental Health Policy, and President, National College of Ireland

She is also:

- Chair of the Further Education and Training Awards Council (FETAC)
- Chair of the Dublin Inner City Partnership
- Chair of the National Guidance Forum
- Member of the National Qualifications Authority of Ireland
- Council member of the Dublin Chamber of Commerce
- Non-Executive Director of the Cement Roadstone Holdings (CRH) plc
- Eisenhower Fellow

Internationally, she has served as the Irish representative to the World Health Organisation and chaired the WHO expert committee on Alcohol and the Workplace. She has received a number of prestigious awards, including recognition by the International Institute for Alcohol and Addiction for her research on drinking behaviour. Recently, Professor O'Connor was awarded an honorary doctorate from Dublin Institute of Technology in recognition of her work in education. She has published widely on the elderly, carers, innovation and enterprise and drinking & smoking behaviours.

Ms. Claire O'Connor, Director, National Disability Authority

Ms M.Claire O'Connor qualified with a BSc.in biochemistry in 1974, and trained as a chartered accountant with Cooper and Lybrand, qualifying in 1977. She joined Esso Teo in 1977 as a management development trainee. She worked on pension fund management, capital budgeting and cash management, while taking a Masters in Organisational Behaviour at IMI/Dublin University (1979). She joined Bank of America in Dublin in 1983 handling the semi-state and hi-tech portfolio of account relationships. In 1988 she joined Irish Life as Head of Investment Research.

In 1994 she took voluntary severance to set up a consultancy business. She was trustee of a number of pension funds, a non-executive director of ICC Bank, for 12 years until its takeover by Bank of Scotland. She also served on the Board of the ICC

Investment Bank and Chaired the Audit Committee. She became Chief Executive of the American Chamber of Commerce in Ireland in September 1998, resigning in August 2001. She was appointed to the Interim Board of the Irish Energy Centre in November 2000. She was appointed a member of Sustainable Energy Ireland in May 2002. She became Director of the National Disability Authority in August 2001.

She worked as Secretary to the Advisory Group to the Minister for Health and Children on the Risk Equalisation Scheme. She was a founder member of a registered charity, "EPIC" Empowering Partnership In Care, a Friend of the Parents & Friends of Cerebral Palsy Ireland, renamed Enable Ireland, and a member of the School Board of CPI Sandymount. She is currently Director of the National Disability Authority

Ms. Mary O'Shea, user of mental health services

Ms. O'Shea is self-employed and lives with her three teenage children and her partner. She likes walking and watching drama on television and she is also the facilitator for the Ennis Friends' Group.

Dr. Mary V. Seeman, MDCM, FRCPC, DSc, Professor Emerita, Department of Psychiatry, University of Toronto

Mary Seeman is a psychiatrist whose research interests lie in the biopsychosocial differences between men and women, especially as these apply to psychotic disorders. This interest has led to over 200 scientific papers and several edited books, among them *Gender and Psychopathology*, published in 1995, and *Parental Psychiatric Disorder: Distressed Parents and their Families*, 1996; 2nd edition 2004. A volume on Women's Mental Health (co-edited with Dr. Sarah Romans) will appear in 2005. Dr. Seeman is currently Graduate Co-ordinator of the Institute of Medical Science, Toronto. In 1995, she was the recipient of the Joey and Toby Tanenbaum Award for her work in gender differences. In 2002, Dr. Seeman received a Queen Elizabeth Golden Jubilee Medal and was awarded an honorary Doctor of Science degree by the University of Toronto.