

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



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The Women's Health Council

The Women's Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. Following a recommendation in the Report of the Second Commission on the Status of Women (1993), the national *Plan for Women's Health 1997-1999* was published in 1997. One of the recommendations in the Plan was that a Women's Health Council be set up as 'a centre of expertise on women's health issues, to foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's issues generally.'

The mission of the Women's Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Its membership is representative of a wide range of expertise and interest in women's health.

The Women's Health Council has five functions detailed in its Statutory Instruments:

1. Advising the Minister for Health and Children on all aspects of women's health.
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.
3. Developing expertise on women's health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.
5. Advising other Government Ministers at their request.

The work of the Women's Health Council is guided by three principles:

- Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women.
- Quality in the provision and delivery of health services to all women throughout their lives.
- Relevance to women's health needs.

In carrying out its statutory functions, the Women's Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health's 'Quality and Fairness' document (2001). This definition states that:

'Health is a state of complete physical, mental and social well being.'

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Foreword



What has been perceived to constitute mental health and mental illness by both the medical profession and the lay population has changed over the centuries. As society's conceptualisation of 'normality' and 'abnormality' is modified by new physical and social circumstances, new pathologies emerge and others disappear. However, throughout the ages, the presence of mental distress in people has been taken to be evidence of social as well as biological deviance (Parsons cited in Kelly and Millward, 2004). People who experience mental health problems have been deemed unfit to participate in social life and excluded from it. Because of the issues presented above, care needs to be taken when talking about 'mental health' and 'mental illness', and the importance of historical, social and cultural dynamics recognised. In light of such considerations, and with no intention to detract from the suffering of people who are affected by mental health problems and their families and friends, an attempt has been made in this report to adopt the most appropriate language to describe mental health difficulties. However, at times, medical terms have been used for the sake of clarity.

Definition



The WHO (1998) has defined mental health as:

- a positive sense of well-being;
- a belief in our own worth and the dignity and worth of others;
- the ability to deal with the inner world of thinking, feeling, managing life and taking risks;
- the ability to initiate, develop and sustain mutually satisfying personal relationships;
- the ability of the mind to heal itself after shock or stress.

Concepts of mental health include subjective well being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realise one's intellectual and emotional potential (WHO, 2003a).

While we can infer that anybody who does not satisfy the criteria above might be experiencing mental health difficulties, the WHO does not actually provide a definition of mental illness. This absence points to the difficulty in achieving consensus on a definition of mental illness due to cultural and epistemological differences among the many stakeholders. In Ireland, mental illness has been defined as the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired, and some form of help is usually needed for recovery (Mental Health Ireland, 2004).

1. Introduction

Background

The Irish health sector is currently undergoing a period of dramatic change. Within this process, it is paramount that mental health and mental health services are given adequate attention. The four goals set out in the national health strategy – better health for everyone; fair access; appropriate care in the appropriate setting; and high performance (Department of Health and Children, 2001b) – have yet to be achieved in the Irish health services, and especially in the context of mental health care (Department of Health and Children, 2003c; O'Keane *et al.*, 2003; Browne, Arisa and Shepperd, 2004; National Disability Authority, 2004). Hence, it is hoped that the ongoing structural reform will bring considerable improvement in this area. The adoption of a 'population health' approach within these new structures would especially help in addressing Goal 1: better health for everyone, and, in this regard, the Women's Health Council welcomes the establishment of a Population Health Directorate within the Health Service Executive. A population health approach reflects the evidence that factors outside the health care sector significantly affect health. In fact, this kind of approach aims "to improve the health of the entire population and to reduce health inequities among population groups" (Health Canada, 2004).

Moreover, the newly constituted Health Information and Quality Authority will have an important role to play in the external monitoring of mental health services as well as aid in the gathering of valuable data, which, will be shown, is currently scarce. A key policy aim of the Health Strategy is to deliver high quality services that are based on evidence-supported best practice (Department of Health and Children, 2003a). This position paper should hence prove valuable evidence to the Health Service Executive for the improvement of mental health services in the new structures both for the general population and especially for women.

Mental Health Context

International data show that mental illness affects between 20 and 25 per cent of all people during some time in their life; 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 (depression, alcohol abuse, schizophrenia and bipolar disorder) (WHO, 2001d). Furthermore, these mental illnesses have been shown to have the substantial macro-economic effect of lowering the Gross National Product in developed countries by three to four per cent (WHO, 2003a). In order to draw attention to the personal, national and global burden of mental illness, the WHO dedicated the World Health Day in 2001 to mental health. Moreover, in the same year it established a mental health Global Action Programme to increase governments' responsiveness to mental health problems. At European level between 15 and 20 per cent of adults have been found to experience some form of mental health problem in pre-accession countries (European Commission, 2003). Because of these statistics, the European Union has chosen mental health as one of its priorities for its Public Health Programme (2003-2008) (European Commission, 2004b).

In Ireland there are no community mental health surveys, unlike in the USA, Canada and the UK. This dearth of data significantly hinders any analysis of mental health and mental illness prevalence at population level as well as their interaction with the physical and social environment. Nevertheless, it

has been estimated that 10 per cent of the general population is affected by depression, and one per cent by schizophrenia (Department of Health and Children, 2001b). Moreover, Irish women and men are experiencing increasing rates of stress¹ (Mental Health Ireland, 2001), which pose a threat to both physical (Segerstrom and Miller, 2004) and mental well being (Herbert, 1997). However, while physical well being has received considerable attention by governments and professional bodies, the importance of mental health is often neglected, and the mental health sector has been called the 'Cinderella' of health services in Ireland (National Disability Authority, 2004).

The mental health sector is the 'Cinderella' of the services in Ireland.

The Women's Health Council hopes that this situation might be rectified 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 to implement the Act and foster high standards in service delivery, and the setting up of the Expert Group on Mental Health Policy, charged with the responsibility of reviewing the national mental health policy in relation to models of care and treatment. The existing policy document *The Psychiatric Services – Planning for the future* (Department of Health, 1984) is twenty years old and, while many of its recommendations are still to be implemented, a new updated strategy is now required. Within any new strategy, the adoption of a gendered approach to understanding, treating and providing services for people affected by mental health difficulties is paramount. International and national data show that mental health problems are gendered in nature and manifestation, and that differential approaches are needed for the successful treatment of women and men. In line with a gendered approach to mental health care, a strategy specifically designed to bring the needs of women users of mental health services into the mainstream was published in the UK in 2002 (Department of Health, 2002).

On the other hand, mental health services in Ireland are gender-neutral at best, and skewed towards the needs of the male population at worst. Even in the most recent government health strategy, gender was not mentioned with regards to mental health. Furthermore, mental health was mentioned as an area of concern for men, but not for women (Department of Health & Children, 2001). This strongly conflicts with the government's admission that women's mental health has not been addressed specifically by the mental health services as far back as 1995 (Department of Health, 1995). This fact was subsequently reiterated in *A Plan for Women's Health*, where mental health services are described as not being in a position to offer women support for their mental health needs (Department of Health and Children, 1997). Discouragingly, The Mental Health Commission has not adopted a gender perspective either, even though they do highlight the need for improved provision in the realms of perinatal psychiatry and eating disorders (Mental Health Commission, 2004b, a). Hence, 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 adopts just such a gendered approach.

The adoption of a gendered approach to understanding, treating and providing services for people affected by mental health difficulties is paramount.

¹ Stress refers to any physical or psychological demand that is outside the norm and that signals a disparity between what is optimal and what actually exists (Herbert, 1997).

Moreover, the quality of mental health care currently being delivered is generally found not to be satisfactory. In the only Irish study available which analyses the provision of mental health care at primary level, a high percentage of general practitioners surveyed had not received any specific training in mental health (Coptly, 2004). In inpatient care, the significant readmission rate to psychiatric hospitals (Daly and Walsh, 2003) suggests that, for many people, admission to hospital and the treatment they receive therein "brings no obvious lasting benefit" (Mental Health Commission, 2004a: 16). The newly appointed Inspector of Mental Health Services, Dr. Teresa Casey, has called the current attitude towards mental health provision: "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 (cited in Bergin, 2004). Furthermore, disadvantage plays a substantial discriminatory role in relation to access and quality of care both on a geographical and personal level. Hence, the areas of greatest need have been found to be receiving the least amount of funding (O'Keane *et al.*, 2003; Browne, Arisa and Shepperd, 2004), and people affected by disadvantage, especially women, have been found to receive less specialised care.

- No data on the prevalence of mental health problems in the population are available in Ireland.
- The quality of mental health care currently being provided is unsatisfactory.
- In the last health care strategy, the government identified mental illness as an area of concern for men but not for women, despite having previously described the provision of mental health services for women as inadequate.

Report Objectives

The Women's Health Council, through this position paper, wishes to achieve a number of aims:

- 1) provide evidence for the gender specific nature of mental health problems and their treatment;
- 2) substantiate the need for an improved knowledge base on mental health and illness in Ireland; and
- 3) advocate for greater quality of care, and within that, increased equity of access to care.

Moreover, the findings presented in this report will support the need for an increased focus on prevention and mental health promotion as well as the vital role that education plays in this field. Finally, the Council hopes to inform and influence the current process of health service reform in relation to mental health services, and the strategic policy formulation being carried out by the Expert Group on Mental Health Policy. As a similar review of mental health policy and service provision is also presently taking place in Northern Ireland, it is hoped that the evidence and recommendations presented here might be of use in an all-Ireland context.

2. The Gendered Nature of Mental Health Problems

Up until recent times, women have been over-represented in prevalence studies of mental health problems (Prior, 1999). This situation has been attributed to historical views of women as inherently irrational and mentally weak (Prior, 1997). 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 proportions, but by different types of difficulties. Women primarily experience anxiety and depression, while men are mostly affected by behaviour and personality difficulties, including alcohol and drug dependence (Payne, 1999; Prior, 1999; WHO, 2001a; Brawman-Mintzer, 2002; Busfield, 2002; WHO, 2004). Similar prevalence rates have been found in cognitive mental illnesses, such as schizophrenia and bipolar depression. However, gender variations are still reflected in their symptoms, treatment and outcomes (WHO, 2001a; Kornstein and Clayton, 2002).

Gender is, therefore, a critical structural determinant of mental health and mental illness that "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" (WHO, 2001a: 2). This statement also highlights the importance of other social factors linked to the prevalence of mental health problems. Amongst such factors, disadvantage is the one most clearly associated with the development of mental illness (Prior, 1999; U.S. Surgeon General, 2001; Morrow, 2003; WHO, 2003a). Hence, the adoption of a gendered perspective that encompasses a broader analysis based on the social determinants of health is necessary for the prevention, diagnosis and treatment of mental illness and the promotion of mental health in the population.

"Gender 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" (WHO, 2001a: 2).

Diagnosis

Despite the fact that mental illness is now recognised to affect both genders in equal measure, it is widely accepted that women and men are affected by different problems and experience them in different ways, as mentioned earlier. One of the most robust epidemiological findings worldwide is that women are proportionately more susceptible to depression², being affected by it at twice the rate of men (Kohen, 2000; Hyman, 2001; Kornstein and Wojcik, 2002; WHO, 2004). Women are also more likely to receive a diagnosis of "panic disorder"³, "generalised anxiety disorder", "obsessive-compulsive disorder", "somatisation disorder", "post-traumatic stress disorder" and are more likely to attempt suicide (Prior, 1999; WHO, 2000b; Kornstein and Clayton, 2002). Prevalence of comorbidity of two or more mental problems is also prevalent in women (WHO, 2001a); and over 90 per cent of cases of eating disorders occur in women (Kornstein and Clayton, 2002; Gucciardi *et al.*, 2004). On the other hand, men 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 (Prior, 1999; WHO, 2001a). However, there are no differences in the rates of severe mental illnesses like schizophrenia and bipolar depression. These affect less than two per cent of the general population

² Depression is predicted to be the second leading cause of global disability burden by 2020 (WHO, 2004).

³ The word "disorder" is considered problematic, however its use in this report is meant to reflect its usage within publications in relation to diagnostic purposes.

(WHO, 2004). Information on the mental health problems most commonly experienced by women can be found in Appendix I (page 56).

Gender Bias in Diagnosis

Gender bias and stereotyping in the diagnosis and treatment of psychological difficulties has been reported since the 1970s (WHO, 2001a). Research has shown that medical diagnostic tools and diagnostic processes reflect the systemic biases found generally in society (Morrow and Chappell, 1999). Gender prejudice is undoubtedly one of these biases. Busfield argues that gender permeates professional thinking and, in turn, it influences the type of treatment offered and the nature of the professional patient interaction (1996). This bias has been shown to result in women being more likely to be diagnosed as depressed by both professionals and family. Studies found that being female increased the likelihood of the clinician diagnosing the patient with depression (Stoppe *et al.*, 1999; Borowski *et al.*, 2000; Bertakis *et al.*, 2001). Furthermore, this gender bias is also present within the family setting, as close relatives are more likely to consider one of their female members to be experiencing depression than their male counterparts (Brommelhoff *et al.*, 2004). This diagnostic bias towards depression does not refute the fact that women have been found to be affected more frequently from depression even in community surveys (Johnson and Buszewicz, 1996b; Kornstein and Wojcik, 2002). However, it might mean that adequate attention is not given to their symptoms in the diagnostic process, and that men might not be accurately diagnosed either.

Diagnosis in Ireland

As previously mentioned, mental health community surveys are not available in Ireland. Hence, all data on the prevalence of mental health problems relies on in-patient surveys. These data are therefore likely to be disproportionately skewed towards more severe mental illnesses that cannot be addressed within primary and community care. In 2002, there were 23,677 admissions to Irish psychiatric hospitals and units, representing a rate of 781.7 per 100,000-population aged 16 years or over. This is considered to be a high rate of morbidity and psychiatric admission for a developed country (Mental Health Commission, 2004a). Males accounted for more than half of all and first admissions (52% and 55% respectively). Male rates for all admissions were higher than the female group in the 20-44 age range and for the 75 and over age groups, while females had a higher rate for groups in the 45-75 age range. A severe social gradient is visible, with highest rate of hospitalisation among the lower-income groups. Males had a higher rate of all admissions than females for most socio-economic groups with the exception of higher professionals, lower professionals, and non-manual workers (Daly and Walsh, 2003). The reasons behind this anomaly will be discussed later in the report, but can be broadly attributed to lack of equity in access to services for disadvantaged women. Diagnoses by gender broadly followed the pattern described above (Table 1 overleaf).

Type of Disorder ⁴	All Admissions in %			First Admissions in %		
	Males	Females	All	Males	Females	All
Organic Psychosis	2.39	2.00	2.20	3.28	2.99	3.15
Schizophrenia	21.96	15.27	18.72	12.58	8.45	10.73
Other Psychoses	1.29	1.06	1.18	2.15	1.95	2.05
Depressive Disorder	26.46	39.34	32.69	31.37	43.08	36.62
Mania	11.16	14.71	12.88	8.35	10.29	9.22
Neuroses	4.33	5.90	5.10	6.78	9.75	8.11
Personality Disorder	3.23	5.16	4.16	2.87	3.31	3.07
Alcoholic Disorder	22.00	11.06	16.70	24.71	14.33	20.05
Drug Dependence	3.95	1.67	2.85	5.71	2.02	3.47
Mental Handicap	1.16	1.05	1.11	0.53	0.56	0.55
Unspecified	2.03	2.71	2.36	2.67	3.18	2.90

Table 1: Diagnosis by Gender. Ireland 2002

As predicted, rates for depression were higher in the female cohort, despite the high number of cases being treated through primary care, and alcohol and drug dependence were higher in the male cohort. The rate for "organic psychoses" was similar, while more males were being admitted for schizophrenia than females despite general equality of prevalence in community studies. This higher rate of male admissions might be related to society's gendered perception of men as more dangerous and in need of control (Prior, 1999), and it is reflected in the fact that males also had a higher rate of involuntary admissions (12.8% against 10.0% for females) (Daly and Walsh, 2003).

- Women and men are affected by mental health problems in equal proportion but by different types of difficulties. Hence gender is a critical determinant of mental health problems.
- Women are affected by depression at twice the rate of men.
- Women are also more likely to experience anxiety, eating disorders, and attempt suicide.
- From the limited data available, these patterns are also found in Ireland.

⁴ The diagnostic categories are reproduced here verbatim from the latest In-Patient Surveys for Psychiatric Hospitals, again highlighting the continuing use of outdated terminology within medical settings.

3. Theories of Gender and Mental Illness

A number of different theories have been proposed for the gender differences in the prevalence of mental health problems and women's greater vulnerability to depression. These can be mainly subdivided into three broad categories: 'women's bodies' or biological theories, 'women's personality' or psychological theories, and 'women's lives' or social theories (Stoppard, 2000). Enough is not yet known to dismiss any of them categorically, and they are all likely to offer some insights into the multiple variables that cause mental health difficulties. Hence, 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

Biological theories underpin the 'medical model' of mental illness, and, in relation to women, usually refer to the concept of heritability and the role played by their physiology in the aetiology and manifestations of mental illness. Scientists have claimed that heritability may account for up to 50 per cent of the risk of major depression (Harvard Mental Health Letter, 2004), and have recently identified a chromosomal variation that might be linked to women's susceptibility to this illness (Zubenko *et al.*, 2003). However, heritability rates have been found to be similar across the population (Kornstein and Wojcik, 2002) and most strongly associated with the more severe mental illnesses (Johnson and Buszewicz, 1996b), thereby reducing the importance of genetic inheritance in gender differences in this field.

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Hormonal factors have also been blamed for women's higher levels of depression (Kornstein and Wojcik, 2002; Parker and Brotchie, 2004), with researchers pointing to the effects played by the onset of puberty, the menstrual cycle, pregnancy, the postpartum period and the menopause on women's mental health. However, "the huge cross-cultural variations found in rates of depression call into question any simple hormonal explanation for women's high rates of depression" (Patel, 2003: 25), and scientific evidence on the hormonal theory has been found to be inconsistent (Abel *et al.*, 1996; Brommelhoff *et al.*, 2004).

Psychological theories

Research suggests that the impact of biological and reproductive factors on women's mental health is mediated or even subsumed by psychosocial factors (WHO, 2001a). When examining gender differences in psychological development and expression, the effect of gender-specific socialisation and coping patterns has been highlighted (Busfield, 2002; Casey, 2002; Kornstein and Wojcik, 2002). 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 (Nolen-Hoeksema, 1995). Alternatively, it has been argued that girls are encouraged to internalise their stress whereas boys are encouraged to act out their stress (Sachs-Ericsson and Ciarlo, 2000).

Busfield points out the role of societal values in the demarcation of particular emotions as feminine or masculine (2002). Hence, in Western society it is considered acceptable and even desirable for women to display fear, anxiety and sadness and talk about such feelings. On the other hand, stereotyped notions of masculinity demand that such emotions and their discussion be discouraged in men, although other emotions such as hate and anger are more acceptable. Furthermore, when men do display hate and anger, they are not labelled as emotionally disturbed, as women are, but are channelled into the language of badness, immorality and delinquency. Therefore, a more appropriate interpretation is advocated by Weissman and Klerman (cited in Sachs-Ericsson and Ciarlo, 2000) who speculated that the different mental health problems experienced by women and men might represent a gendered expression of a shared underlying emotional difficulty.

The different mental health problems experienced by women and men might represent a gendered expression of a shared underlying emotional difficulty.

Psychological developmental theories are supported by evidence from longitudinal studies. Differences in the mental health of boys and girls start to appear at the age of 13 and continue to rise for the next few years. By age 18, their lifetime prevalence rates are similar to those of adults (Greenberger, 2001; Kornstein and Wojcik, 2002). This statistic is also found within admission rates for Irish adolescents. More boys are admitted to psychiatric children's centres up to 13 years of age, but from age 13 to 17 girls predominate. More girls presented with "depressive disorder" (9 admissions for girls vs. 2 for boys), while two-thirds of boys were affected by "conduct disorder" (Daly and Walsh, 2003). Casey has claimed that during adolescence, and as they become aware of the norms limiting them through the patriarchal social model, girls "lose their voice and confidence" (2002: 507), resulting in a steep increase in their depression rates.

Social theories

The influence that social factors exert on mental well being cannot be underestimated. "Women's mental health cannot be understood in isolation from the social conditions of [their] lives" (Morrow and Chappell, 1998: 3), and it needs to be contextualised within them (Stoppard, 2000). Women's own explanations for poor mental health has been found to centre around three main themes: the social legacy of being a woman, the heavy work load of women and the social pressures of conforming to the feminine ideal (Holmshaw and Hillier, 2000).

Social Status

The 1998 WHO World Health Report stated that women's health is inextricably linked to their status in society. It benefits from equality and suffers from discrimination (WHO, 1998). However, the 1997 UNDP report states that no society treats its women as well as its men (cited in Astbury and Cabal, 2000). Hence, it is unsurprising to find high rates of mental health problems among women, especially in relation to depression. Women's status in society is still lower than men's even in developed countries, and this is certainly the case in Ireland (United Nations Development Programme, 2004). In the most recent UNDP report, Ireland ranked 14th in the gender-related development index, last of the ten most developed countries in the world, and 16th on the gender empowerment measure,

second only to Japan for its lack of gender empowerment (United Nations Development Programme, 2004). The Equality Authority identified gender inequalities in the political, economic, caring and cultural arenas (2002). Female representation in the Dáil has risen by only one per cent, to 13 per cent, over the past 10 years. Women account for only three per cent of managing directors, nine per cent of secretaries-general in the civil service and seven per cent of high court judges (National Women's Council of Ireland, 2002). In the economic sphere, women's salaries in Ireland are lower than those of their male counterparts, with female average hourly earnings 28.4 per cent below male earnings in June 2002 (Indecon, 2002). Moreover, the gender gap appears to be widening instead of narrowing in recent years. Strikingly, the gender pay gap persists even in relation to recent third-level graduates. Factors found to influence this financial discrimination are related to the predominance of women in low-paid, part-time, and insecure jobs.

Women's health is inextricably linked to their status in society (WHO, 1998).

Multiple Roles

Apart from their lower social status, women are disadvantaged also by the multiple roles they perform in society as carers, partners and workers. Women of reproductive age normally carry the triple burden of productive, reproductive and caring work at the same time (WHO, 2001a). This situation has been found to cause women considerable amounts of stress (Holmshaw and Hillier, 2000; WHO, 2000b; Shrier, 2002) and is normally referred to as 'role overload' (Lasswell, 2002), 'role strain or conflict' (Shrier, 2002) or the 'Superwoman syndrome' (Shire, 2002). In an Irish study, Merriman and Wiley (1996) found that one in five married women and mothers had taken tranquillisers at some time, compared to only 7 per cent of single women and those who had no children. The stress is generally caused by the well documented imbalance in caring responsibilities within married 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 (Sachs-Ericsson and Ciarlo, 2000; Lasswell, 2002; Strazdins and Broom, 2004). In fact, numerous studies have found that married men are in general more satisfied with being married than married women are. Moreover, marital dissatisfaction has been found to increase during the years when child care is paramount, further pointing toward the role played by parenting responsibilities in women's stress (Lasswell, 2002). An Irish marriage counselling study found that extreme marital unhappiness was quite considerable, especially among women (Condon, 2004a). In an unhappy marriage, women are more likely than men to become depressed, and women have been found to be more sensitive to the effects of divorce, demonstrating higher rates of depression, whereas men report more alcohol problems (Kornstein and Wojcik, 2002; Lasswell, 2002).

Women carry the triple burden of productive, reproductive and caring work at the same time (WHO, 2001a).

Multiple roles also have the potential to have protective qualities for mental health (Sachs-Ericsson and Ciarlo, 2000; Shrier, 2002).

"However, the potential for role conflict and for role overload or strain; the greater likelihood of women's working in jobs that have less autonomy and control over hours and work content; the difficulties in finding and keeping good quality child care; and confusion over internalised values and roles as mothers and partners as well as workers all increase the likelihood of women experiencing stress-related physical and emotional difficulties, particularly depression and anxiety". (Shrier, 2002: 528)

This is especially true, when caring responsibilities are not valued in society (Holmshaw and Hillier, 2000). Connolly recently highlighted how higher work participation rates by women in Ireland without any significant shift in the demands posed by their traditional roles have been reflected in an increased rate of depression in married women, whereas rates for married men have decreased (2003). The strain caused by multiple roles is even greater for lone mothers, as the absence of a co-parent to share even a part of the workload results in particularly stressful lives (Lasswell, 2002). In a study on the well-being of Irish families it was found that one-parent single families have adverse repercussions on mothers, who tend to have lower levels of psychological well-being than other parents (McKeown, Pratschke and Haase, 2003). Hence,

"to fully understand gender differences in mental health there is a need to integrate a gender role analysis with a structural analysis of the determinants of health, because gender roles intersect with critical structural determinants including social position, income, education and health insurance status". (WHO, 2001a: 13)

Stressful Life Events

Throughout their lifetime, women are also more likely to be affected by stressful events and traumas, especially in relation to physical and sexual abuse (WHO, 2001a; Department of Health, 2002), which can cause serious physical and mental health repercussions. General population surveys in the USA reveal that about one third of all married women can experience some form of physical abuse during their marriage. Violence in dating and cohabitating relationships may be even higher. Sexual harassment affects a fourth to half of women employees and students. About one fifth of adult women have been raped. Many women also suffer from the effects of abuse experienced in childhood. Child sexual abuse, defined as any sexual contact from fondling to intercourse, affects 20 to 30 per cent of all girls. Physical abuse of girls, with injury or injury potential, affects approx 10 to 20 per cent of American women (Mowbray *et al.*, 1998). In Ireland, a study conducted by the Dublin Rape Crisis Centre in a representative sample from the general population, found that one in five women had experienced child sexual abuse, and one in five women had also been sexually assaulted as adults. A lifetime experience of sexual abuse and assault was substantially higher for women than men in Ireland (McGee *et al.*, 2002).

Women are more likely to be affected by physical and sexual abuse.

Experience of abuse and sexual violence has been found to be very common among particularly disadvantaged groups of women. Many women resort to alcohol and drugs abuse as a way of coping with sexual and physical abuse (Hedrich, 2000; Klee, Jackson and Lewis, 2002). A history of serious physical and/or sexual abuse is also prevalent among homeless women, abuse often being behind their decision to leave home in the first place (Carlson, 1990; National Women's Council of Ireland, 2000; Smith, McGee and Shannon, 2001). A similar situation can be found among women in prostitution with a majority of them found to have experienced sexual and/or physical abuse prior to being drawn into prostitution (McGee *et al.*, 2002; Farley, 2003) as well as afterwards (Macready, 1998; Church *et al.*, 2001; McGee *et al.*, 2002; Farley, 2003). Finally, between 50 to 80 per cent of incarcerated women have been found to have experienced child abuse and violence (Veysey, 1998; Pate, 2000; Pollack, 2002) (More information on all these groups of marginalized women can be found in Appendix II, page 60).

Not surprisingly, rates of depression are three to four times higher in women exposed to childhood sexual abuse or physical partner violence in adult life (Kornstein and Wojcik, 2002). Following rape, nearly one in three women will develop "post-traumatic stress disorder" (PTSD) compared to one in twenty non-victims. Self-harm and suicide attempts are also linked to physical and sexual abuse (Mowbray *et al.*, 1998; WHO, 2001a). Furthermore, violent victimisation and its sequelae also increase the risk of unemployment, reduced income and divorce, further weakening women's social position by affecting other determinants of health, as well as increasing vulnerability to depression and other psychological problems. Hence, societal awareness of the trauma caused by violence and abuse and its willingness to combat them are of critical importance in the promotion of women's mental health.

Disadvantage

The psychological and emotional strain caused by the above social factors is further exacerbated in cases of social disadvantage. A consistent reverse relationship has been found between social class and mental health (Prior, 1999; U.S. Surgeon General, 2001; WHO, 2003a; Women's Health Council, 2003b; Balanda and Wilde, 2004; European Commission, 2004b). Worldwide, women are consistently poorer than men due to their lower levels of education, lower rates of pay, doing more part-time, and 'casual' work and consequently being less likely to ensure a financially secure old age (Astbury and Cabral, 2000).

Worldwide, women are consistently poorer than men.

This situation holds true in Ireland, too, where women have been consistently found to be at greater risk of falling into poverty than men (23% vs. 19%), while the gap between the genders has been widening in recent years (Combat Poverty Agency, 2002)⁵. Particular groups of women have also been found to be at even greater risk of poverty because of their inability to access education, training and employment, such as lone mothers, women with disabilities, lesbian women, women living in rural areas, carers, older women, Traveller women and asylum-seekers (Women's Health Council, 2003b). Social isolation and discrimination are also common experiences for many of these women.

⁵ Moreover, both relative and absolute poverty negatively influence mental health (WHO, 2003b). In Ireland, while rates of absolute poverty have been decreasing over the last decade, relative poverty has been on the increase (Combat Poverty Agency, 2002).

Female gender is still a predictor of lower status and lower pay in Ireland.

Unsurprisingly, disadvantaged women have been found to experience higher rates of depression than the general population (Blanch and Lubotsky Levin, 1998). Moreover, poverty also has a dramatic impact on women's ability to access services and treatment; it is a contributing factor to homelessness; and makes them financially dependent and more likely to remain in abusive relationships (Morrow and Chappell, 1999). Hence, anti-poverty strategies with a clear gender-proofing element need to be implemented in order to reduce disadvantage in society, and its impact on women's mental health. Further information on particular groups of disadvantaged women can be found in Appendix II (page 60).

A new integrated framework

The fact that psychological and social factors greatly influence the type, onset and manifestations of mental illness in men and women has now been widely documented. Increasing international rates of psychological problems worldwide (WHO, 2001d) call for an increased awareness of how the circumstances in people's lives affect their mental health. While the neurological and physiological components of mental illnesses, especially the most severe ones, cannot be denied, what is needed is a greater contextualisation of mental health difficulties within current social realities. This is especially true when analysing women's most common mental health problems, which are critically influenced by gendered perspectives of women's appropriate behaviour and role in society and by the endemic discrimination and disadvantage that they experience in daily life. Moreover, Busfield (2002) argues that nothing is fixed in relation to the current gender diversification of mental illnesses, and changes in social dynamics could see their future regendering. For example, as alcohol and drug use by women becomes more acceptable, female rates of dependence might rise⁶. Likewise, as society moves towards greater equality for women within the workplace and the family setting, men might experience gender role confusion and male rates of depression might increase.

Hence, what is needed is a new framework for the understanding and treatment of mental illness and the promotion of mental health. What this entails is not the wholesale rejection of the 'medical model' or of the biological theories on which it is based, but the incorporation of psychological and social variables into it. The vulnerability–stress model goes some way towards achieving this aim, as it combines biological and psychological perspectives, as well as their interaction (Kohen, 2000). This model merges the amount of a person's predisposition toward certain illnesses with the occurrence of certain extra–pressures, which may bring on the onset of disease. Particular stressors can precipitate the onset or relapse of any kind of mental health problem, while specific personal vulnerabilities determine the type of illness that is experienced. An additional social layer must be added to this model, insofar as certain characteristics *per se* are catalysts for the presence of stress. Amongst them, female gender and disadvantage have been identified as highly significant. Therefore, social policies designed to improve gender equality and reduce social inequalities in general will prove as, if not more, beneficial to the promotion of women's mental health as advances in pharmacological research.

⁶ Drinking problems are already appearing to be increasing in young women and the gender gap closing (Rhodes and Goering, 1998; Canterbury, 2002).

- Gender differences in the prevalence and manifestations of mental health problems have been attributed to biological, psychological and social characteristics.
- Biological theories focus on the role of genetic inheritance and hormonal factors. However, they have been unable to explain the variance of prevalence rates internationally.
- Psychological theories highlight the importance of gendered social development and coping styles in women and men.
- Social theories focus on the lower social status of women in all societies; the stress caused by the multiple roles they perform; their greater likelihood of being affected by physical and sexual abuse, and their greater exposure to disadvantage.
- An integrated framework which encompasses all these perspectives is the best approach to understanding mental health and mental health problems.

4. The Gendered Nature of Treatment

Gender differences appear not only in relation to the kinds of mental health problems experienced by women and men, but also in their patterns of help seeking and their treatment. Women are more likely to seek help from and disclose mental health problems to 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 (Busfield, 1996; Prior, 1999; WHO, 2001a). 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 (Abel *et al.*, 1996; Blanch and Lubotsky Levin, 1998; Mowbray *et al.*, 1998; Prior, 1999; WHO, 2004). Finally, recent clinical studies have also highlighted different reactions to medication, such as slower absorption and distribution, and more severe side effects⁷, indicating that physiological differences need to be taken into account in relation to drug dosages and prescription (Greenberger, 2001; Brawman-Mintzer, 2002).

Gender Bias in Treatment

As mentioned above, women have been found to be twice as likely to be prescribed psychotropic drugs by their general practitioners, and less likely to be referred for specialist treatment by them. This statistic has given rise to grave concerns that women's mental health problems are being neglected or not given proper attention (Rhodes and Goering, 1998; Morrow and Chappell, 1999; Prior, 1999; Batt and Nic Gabhainn, 2002; Department of Health, 2002). In particular, the dominant concern is that health care services are addressing the symptoms of women's mental health problems, while failing to address their root causes. On the other hand, men have been found to be more likely to be hospitalised, both voluntarily and involuntarily. This trend again stems from a gendered perception of men as more dangerous and in need of control (Prior, 1999). This approach is likely to be counterproductive and cause more distress than bring benefit to their mental health. Hence, treatment models that are not steeped in gender stereotypes but actually address the realities of gendered experience are likely to be more beneficial to both women and men.

Women are twice as likely to be prescribed psychotropic drugs by their GPs, and less likely to be referred for specialist treatment by them.

Treatment in Ireland

Again, no gender-disaggregated information is available in Ireland 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%) (Daly and Walsh, 2003). No analysis of these statistics is available, but it may 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

⁷ Medication-related weight gain is also an important factor to be considered within treatment. Clinical report suggest that more women than men discontinue medication intake due to weight gain, particularly for women who may have experienced weight gain as part of the clinical profile of their disorder (Blehar and Norquist, 2002).

other hand, 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 inherent inequity in access to care which transpires from both of the above statistics will be further discussed later. The paucity of information at our disposal greatly hinders any further analysis of the current situation in relation to treatment and service provision in Ireland not only from a gendered perspective, but also in general terms.

No gender-disaggregated information is available in Ireland in relation to treatment at either primary or secondary level.

Recovery

Before progressing any further in this analysis, it must be emphasised that recovery from mental illness is a realistic possibility (Lynch, 2004) and mental health services should be based on the principle of recovery and reintegration rather than only maintenance (Groarke, 2003; Schizophrenia Ireland, 2003). Recovery may imply the disappearance of symptoms, or a situation in which the individual lives a productive and meaningful life despite their presence. Lynch states that approximately one in three people diagnosed as having schizophrenia recover; and so do up to 50 per cent of people diagnosed as having depression (2004).

Recovery from mental illness is a realistic possibility.

While no data are available on recovery rates for either the general or the in-patient population in Ireland, readmission rates point to the frequent lack of benefit derived from treatment within psychiatric hospitals. On the other hand, non-medical interventions, such as employment training, counselling and psychotherapy, and peer support groups have been found to play a key role in the recovery process of both women and men (Schizophrenia Ireland, 2002). The concepts of self-determination and empowerment are also key to the recovery model, and have been found to be particularly salient for women receiving treatment (Abel *et al.*, 1996; Gomel, 1997; Blanch and Lubotsky Levin, 1998; Department of Health, 1999; Morrow and Chappell, 1999; Department of Health, 2002). Hence, they will need to be considered in the formulation of any mental health strategy.

- Women and men seek and receive treatment for mental health difficulties in different ways.
- Women are less likely to receive specialist care and twice as likely to be prescribed psychotropic drugs.
- Only inpatient data are available in Ireland, however, here women are also less likely to be admitted to inpatient settings, but more likely to be admitted to private hospitals, highlighting inequity in access according to social class.
- Recovery is possible and women are more likely to recover from mental health problems.

5. Quality of Care

Mental health services in Ireland are presently grossly under-funded, receiving less than 7 per cent of the health care budget, despite the fact that mental health disability contributes approximately 20 per cent of total health related disability (Mental Health Commission, 2004a). Funding has decreased from 10.6 per cent of the health care budget in 1990 to 6.8 per cent in 2003 (Mental Health Commission, 2004b)⁸. Thus, the mental health sector has been rightly called the 'Cinderella' of health services (National Disability Authority, 2004). Moreover, funding is not distributed effectively or according to need (Department of Health and Children, 2003c). This situation has not only been harmful to the mental health of people experiencing difficulties, but also to their carers, who are left to shoulder the responsibility of looking after them without proper supports in place. Hence, an improvement in service provision across the sector should be a government priority. Moreover, in order to achieve real gains, such improvement needs to be evidence-based and targeted to the specific needs to different population groups.

Funding for mental health care has decreased from 10.6 per cent in 1990 to 6.8 per cent in 2003 despite the fact that mental health disability contributes to approximately 20 per cent of total health related disability.

As shown by the diagnostic evidence, mental health problems are clearly gendered. It follows that treatment programmes and service provision need to adopt a gendered approach in order to be effective. This has now been advocated in numerous women's health publications nationally (Batt and Nic Gabhainn, 2002; Women's Health Council, 2002) and internationally (for example: Busfield, 1996; Gomel, 1997; Payne, 1999; Prior, 1999; Astbury and Cabral, 2000; Kohen, 2000; WHO, 2001a; Busfield, 2002; Kornstein and Clayton, 2002; Morrow, 2003). While the UK has now a mental health policy specifically dedicated to the needs of women (Department of Health, 2002), and there is some evidence of an increased gender awareness in policies in Canada (Morrow and Chappell, 1999; Morrow, 2003) and the USA (Lubotsky Levin, Blanch and Jennings, 1998; Kornstein and Clayton, 2002), mental health services in Ireland are still very much gender-neutral at best, and skewed towards the needs of the male population at worst. However, 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 adopts a gendered approach. Moreover, the diversities as well as the commonalities within the female and male genders should be acknowledged, as gender is but one of the social determinants of health. Service agencies and providers should, therefore, be aware of the diverse needs of patients, for instance in relation to their age, ethnicity and sexual orientation, and strive to cater for them in a satisfactory manner. A short overview of the mental health services currently offered to women in general and some recommendations towards their improvement is presented below⁹. To provide the same analysis in relation to male services is beyond the scope of this report. However, many of the recommendations would undoubtedly prove beneficial in this context, too.

Mental health services in Ireland are still very much gender-neutral at best, and skewed towards the needs of the male population at worst.

⁸ Ireland also had the lowest numbers of psychiatrists per capita in the European Union in 2000 (pre-accession data) (European Commission, 2004b).

⁹ Special attention needs to be given to the needs of marginalised groups of women, and specific information and recommendations in this regard can be found in Appendix II.

A Model of Care for Women

"Women often do not receive appropriate mental health... services whether they are in hospitals, prisons, nursing homes, addiction programmes or community settings. Ineffective treatment is costly in terms of money expended and in the perpetuation of human suffering". (Lubotsky Levin, Blanch and Jennings, 1998: xi)

A number of other authors have also claimed that insufficient attention in treatment and rehabilitation services has been given to women's needs (for example: Goldicott, 1996; Mowbray *et al.*, 1998). This situation is also mirrored by Irish studies (Batt and Nic Gabhainn, 2002). Blanch and Lubotsky Levin attribute the failure of mental health delivery to three factors:

- The patriarchal structure of mental health delivery systems;
- Their conceptual inability to integrate psychosocial factors into the medical model;
- The fragmentation of health and social services, leading to segregated and discontinued care (1998).

What is actually needed is a model based on "a **community care model** for primary care and community systems backed by inpatients psychiatric beds when necessary" (Kohen, 2000: 219). 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 (2000). A **person-centred approach** also needs to be adopted, in which women's specific mental health concerns and life priorities are taken into account in the design and implementation of their treatment plan (WHO, 2001a). Hence an element of choice and self-determination through empowerment needs to be present, whenever possible. As previously seen, empowerment is also a key element of the recovery process.

Empowerment is a key element of the recovery process.

A **holistic approach** to patient care 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 (WHO, 2003a). Mental illness has been associated with a significant risk for any cardiovascular disease, especially in menopausal women (Keyes, 2004; Wassertheil-Smoller *et al.*, 2004). This is especially significant within an Irish setting, where cardiovascular disease is the most common cause of death for women (Codd, 2001). Consideration for the many social roles that women perform, as partners, workers and, especially, as parents, is also paramount¹⁰. In fact, fear of losing custody of their children is one of the main barriers for women accessing mental health services, while maintaining custody has also been found to be critical for recovery (Goldicott, 1996; Morrow and Chappell, 1999). The provision of childcare facilities and nursery schools within services for women as well as the availability of mother and baby units

¹⁰ Recommendations for the treatment needs of women suffering from mental health problems during the maternity period can be found in The Women's Health Council's report *Early Life Influences* (forthcoming).

within inpatient care are crucial in order to encourage women to access health services, as these make attendance practically and financially easier. In addition, the presence of childcare facilities alongside health care clearly communicates to women that their role as mothers will not be automatically jeopardised by their mental health status (Kohen, 2000; WHO, 2001a). When absolutely necessary, separation from children should be carried out in the least traumatic manner possible, and visits should be encouraged. An Irish study exploring psychiatrists' views on visits by children in acute psychiatric hospitals found that the benefits of allowing parents some contact with their children outweigh any possible negative aspects. However, at the moment no adequate facilities are available (O'Shea *et al.*, 2004), and this should be remedied.

The voices of current and past women users of mental health services must also be heard within service delivery, in order to improve the quality and reach of such services¹¹ (Gadd, 1996; Lubotsky Levin, Blanch and Jennings, 1998; Morrow and Chappell, 1999; Kohen, 2000). The new UK policy for women's mental health (Department of Health, 2002) advocates that women users be involved in commissioning services, participating in patient councils and fora, their own care planning and treatment decisions, and clinical governance. **Consultation** with the NGOs that represent them is also felt to be beneficial (Johnson and Buszewicz, 1996a). While **advocacy services** for people experiencing mental health problems are currently underdeveloped in Ireland (National Disability Authority, 2004), service providers as well as the community and voluntary sector are increasingly aware of need. A recent report on developing advocacy services identified mental health problems as a priority (Goodbody Economic Consultants, 2004). A group of NGOs have formed the Alliance for Mental Health¹². However, a coalition specifically championing the concern of women mental health care consumers should also be instituted.

Finally, mental health settings are generally dominated by males (Goldicott, 1996), and a gender rebalancing within mental health services has been advocated (Kohen, 2000), both in terms of security issues, and in relation to an increased awareness of gender issues and women's needs as patients as well as in the context of their other social roles. In Ireland, however, psychiatric services are not predominantly staffed by men. Psychiatric nursing is mainly carried out by women (An Bord Altranais, 2004) (see Table 2 overleaf), and, more significantly, the percentage of female consultants is generally high, and the highest of all medical specialties (Comhairle na n-Ospideal, 2004) (see Table 3 overleaf)¹³. The fact that despite this apparent gender balance in staffing levels at consultant level, mental health care still does not take account of gender issues points to an entrenched gender-neutral approach to health and illness in Irish services.

11 In this regard, The Women's Health Council welcomes the public consultation approach taken by the Expert Group on Mental Health Policy.

12 For information on the Alliance for Mental Health can be found on www.mentalhealthireland.ie

13 However, this situation might change as psychiatry is currently the area of specialisation of lowest interest for females (Condon, 2004b).

Total of Psychiatric Nurses

	Females	Males
2003	8,081	3,500
2002	7,953	3,558
2001	7,720	3,508
2000	7,442	3,393
1999	7,257	3,301

Permanent Consultants

	Females		Males	
2004	115	51%	112	49%
2003	105	49.76%	106	50.24%
2002	98	48.28%	105	51.72%
2001	83	44.6%	103	55.4%

Table 2 Registered Psychiatric Nurses by gender.¹⁴ Table 3 Permanent Psychiatric Consultants by gender.¹⁵

Primary care

As mentioned, no comprehensive data are available in Ireland in relation to treatment and service provision for mental health difficulties 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. One study of mental health care in general practice has been carried out in the South Western Area Health Board (SWAHB) (Coptly, 2004). This study paints a very bleak picture in relation to the quality of care currently being provided to the Irish public.

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One of the most worrying statistics in relation to mental health treatment is that the majority of women and men experiencing emotional distress and/or psychological difficulties are neither identified nor treated by their doctor (WHO, 2004). Hence, the first step to improve mental health treatment is to increase awareness and provide training to general practitioners in this area. Coptly found that 68 per cent 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 (2004).

Sixty-eight per cent of GPs in the SWAHB had received no specific training in mental health care (Coptly, 2004).

This lack of training should raise substantial concerns, given that when they are diagnosed with a mental health problem, women are more likely to continue receiving treatment within primary care (Blanch and Lubotsky Levin, 1998). Most people in Ireland receive their mental health treatment within the primary care setting, with 10 to 20 per cent of primary caseload falling under the category of mental health in the SWAHB. The three most prevalent mental health conditions in patient population were found to be "anxiety disorders" (49%), depression (24%) and emotional difficulties (20%) (Coptly, 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, these are probably primarily men.

¹⁴ Table compiled from statistics from An Bord Altranais' yearly registration statistics, www.nursingboard.ie

¹⁵ Table compiled from statistics from Comhairle na n-Ospideal's yearly staffing reports, www.com-n-osp.ie

While the reliance on psychotropic drugs for the treatment of depression and anxiety is well documented both internationally (Busfield, 1996; Prior, 1999; WHO, 2001a) and in Ireland (Lynch, 2004), different reasons have been given for this situation. Some commentators draw attention to the ever-increasing influence of pharmaceutical companies (Morrow and Chappell, 1999; Lynch, 2004). It has also been argued that it is the lack of alternatives that draws GPs toward a pharmacological solution (O'Morain, 2004). Nevertheless, 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, such as counselling, which have been found to be beneficial and are preferred by women. However, Coptly again found a communication gap between primary care providers and specialists, as a vast majority of GPs (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 (Department of Health and Children, 2001c), will hence be a welcome development and should prove beneficial for the provision of comprehensive mental health care programmes at both primary and secondary levels¹⁶. However, critics have emphasised that the attention given to mental health problems within the strategy is too limited (O'Morain, 2004). Nevertheless, the inclusion of mental health services within primary care would increase the viability of a shared model of care for mental health, reducing the need for unnecessary medication, as well as hospital admission, and improving continuity of care after discharge.

In the meantime, GPs remain ideally placed to provide care for less severe mental illnesses, particularly because of their ongoing contact with some of the high-risk groups, such as the bereaved, the chronically ill, carers, women in the postnatal period, and mothers with young children (Carney and Strathdee, 1996). Hence, adequate resources should be invested in mental health training for GPs. In the UK an optional psychiatric module is now included in GP training, while in Austria GP training is being reorganised to include a mandatory psychiatric course (European Commission, 2004b). In Coptly's study, GPs expressed the wish to expand their mental health skills through counselling, brief intervention, cognitive behaviour therapy, and problem solving training (2004). The WHO recommends similar training for general practitioners dealing with mental health issues (2000a). Two Cochrane reviews were recently carried out on the effectiveness of counselling and psychosocial interventions within primary care. Their findings are highly encouraging. The first one found counselling to be significantly more effective than 'usual care' in the short term, provide a high level of client satisfaction and not to increase costs (Bower *et al.*, 2004). The long-term benefits, however, were not significant. This differentiation points to the fact that while primary level interventions might be sufficient at the onset of mental health difficulties, more specialised treatment might be necessary if the problems are not resolved. The second one found good evidence that problem-solving treatment within primary care is effective for major depression, although it pointed out that more research is needed in this field (Huibers *et al.*, 2004).

¹⁶ Considering their importance in the detection and treatment of mental health problems, it is also rather worrying that Ireland has got the lowest number of GPs per capita in the European Union (pre-accession data) (European Commission, 2004b).

Counselling and other therapeutic services

Studies of women accessing primary care and mental health services have found widespread dissatisfaction with over-reliance on psychotropic drugs. The use of pharmaceuticals to respond to women's mental distress was perceived to be a way to cover up their problems instead of addressing them. In addition, there are concerns that it could lead to dependence and addiction. Hence, most women express a preference for counselling and 'talking therapies' rather than medication (Morrow and Chappell, 1999; Batt and Nic Gabhainn, 2002; Department of Health, 2002; Coptly, 2004). An in-depth study of women's mental health services needs in Ireland carried out by The Women's Health Council (Batt and Nic Gabhainn, 2002) found that while counselling services are currently available in special circumstances, such as in cases of crisis pregnancy, rape and/or sexual abuse, crime and marital problems, no such services are provided for women to cope with the crises which arise in their lives and which threaten their mental health. Women expressed a marked preference for a more proactive approach, so that they could access counselling at an earlier stage in the stress cycle and prevent the exacerbation of their mental and emotional distress. A clear preference for counselling services to be provided by health boards and GPs in a location off-site from key services, such as community or family centres and GP surgeries, was also identified.

Most women prefer counselling or 'talking therapies' to medication.

The importance of self-help or peer-support groups should also be mentioned (Gomel, 1997; Morrow and Chappell, 1999; Department of Health, 2002). The *Plan for Women's Health 1997-1999* recognised their importance. However, such groups are at present mainly organised and run through NGOs and/or community groups, as in the case of lone mothers, survivors of adult and childhood sexual violence, women affected by eating disorders, or lesbian women. As a consequence, their funding is often precarious.

Finally, the use of other complementary therapies, such as reflexology and aromatherapy, has also been found to be beneficial to the promotion of women's health (Department of Health and Children, 1997; Morrow and Chappell, 1999; Department of Health, 2002). In fact, their use has increased in Ireland in recent years, with a fifth of men and almost a third of women stating that they had attended an alternative/complementary therapist in 2002 (Kelleher *et al.*, 2003). Hence, awareness of them needs to be increased and promoted, especially at primary care level. Finally, in relation to both counselling and complementary therapies, equitable availability should be implemented. These treatments are often expensive, and women on low incomes cannot afford them. Therefore, access to them should be facilitated through innovative contracting mechanisms which would allow GPs to prescribe them to their clients instead or alongside traditional medication.

Community care

The only data available in relation to community care in Ireland deals strictly with admission rates, which are disaggregated only in terms of health board area and, thus, cannot provide any information on social variables, diagnoses, treatments or recovery rates. This is particularly worrying, as community services have been shown to be effective in addressing mental health needs, and information derived from this approach could be particularly useful in detecting the underlying dynamics of recovery. A 30-month long Canadian Mental Health Association study found that community mental health services reduce hospital admissions by 86 per cent and crisis incidents by 34 per cent. Moreover, a person with mental illness can be cared for in the community for CAN\$98 a day (€62), compared to CAN\$468 (€295) in a hospital (Swanson, 2004). 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). "The wider, more flexible and more accessible range of services that can be offered through community care offers scope for the development of ways of working that are more helpful to women with mental health problems" (Johnson and Buszewics, 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. Partnerships with NGOs for the provision of specialised services are also promoted (Department of Health, 2002).

Twenty years on, community care services in Ireland are still lacking, especially in relation to basic outpatient treatment facilities like day hospitals and residential centres.

Based on international recognition of the benefits of a community care approach, the government incorporated this view in its mental health policy published in 1984, *The Psychiatric Services - Planning for the future*. One of the recommendations of the report was the establishment of a comprehensive community-oriented mental health service as an alternative to institutional care (Department of Health, 1984). However, twenty years on, community care services in Ireland are still lacking, especially in relation to basic outpatient treatment facilities like day hospitals and residential units (Keogh, Roche and Walsh, 1999; Browne, Arisa and Shepperd, 2004; Kelly, 2004). Furthermore, the inpatient model of care is still the dominant area of interest of many care providers (Owens, 2004). Hence, more needs to be done to redirect mental health service provision towards community care both in terms of home-based treatments, which have been found to be successful even in the case of severe mental illness (McCauley *et al.*, 2003), and of community facilities. Finally, a special word of caution needs to be expressed in relation to funding for community care. While this approach has been evaluated as either cheaper (Swanson, 2004) or equivalent in cost (Owens, 2004) to inpatient care, it is, nevertheless, more vulnerable to cost cutting (Prior, 1999). Hence, long-term budgetary guarantees need to be put in place in order to ensure that 'care in the community' does not become 'care by the community' (Bredin, 1994) during times of budgetary contraction.

More needs to be done to redirect mental health service provision towards community care.

Inpatient care

While the benefits of community care have been highlighted, it is unlikely that the need for inpatient care will completely disappear in the future. Moreover, hospital admission also has some positive effects for women as it can offer respite from stressful personal circumstances (Johnson and Buszewicz, 1996a). However, women in general have been found to experience psychiatric hospital settings as punitive rather than therapeutic, and have found them to induce an increased sense of powerlessness (Department of Health, 2002). 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 (Kohen, 2000). 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 (Department of Health, 2002).

Women experience inpatient settings as punitive rather than therapeutic.

As the Irish system is still dominated by the inpatient model (Owens, 2004), 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. 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 (Browne, Arisa and Shepperd, 2004; Mental Health Commission, 2004b). In addition, or, arguably, because of this medical model, many patients in Irish psychiatric hospitals have been found to feel excluded from treatment decisions, find their time in hospital stressful and stigmatising, and paradoxically, often have reduced access to their therapists. "Women in particular find their inpatient stay intimidating" (Owens, 2004). Hence, greater awareness of women's needs should be promoted alongside a more patient-centred approach conducive to greater patient involvement and self-determination in treatment planning and delivery. Moreover, annual statistics point to a readmission rate of 70 per cent (Daly and Walsh, 2003), highlighting the fact that most patients do not gain much benefit from the present inpatient treatment based on the medical model. Hence, treatment plans need to be modified and rendered multidisciplinary. Again, with regards to women, access to psychologists, counsellors and other allied professionals would be highly recommended.

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 care. In the 2002 Report, the Inspector of Mental Hospitals claimed that long term stay patients had not participated in Breast Check even in those areas where this services was available (Department of Health and Children, 2003c). This situation should be rectified and all inpatients should have access to physical screening and treatment programmes like the rest of the female population.

Involuntary Admissions

Within inpatient care, special mention needs to be made of the possibility of involuntary admission. At twice the rate of England and four times that of Italy (O'Brien, 2004b), Irish rates of involuntary

admission have been deemed to be high by European standards (Walsh, 2002). Rates in Ireland have been consistently lower for women than for men. In 2002, 2,717 people were admitted to psychiatric hospitals involuntarily. 12.8 per cent of total and 14.7 per cent of first non-voluntary admissions were for male patients in 2002 compared to 10.0 and 12.2 per cent respectively for females (Daly and Walsh, 2003). However, due to their potential for the infringement of human rights, involuntary admissions need to be carefully monitored and the appropriate checks and balances implemented. Kelly (2004) claims that the last few years have seen some of the most significant advances in Irish mental health legislation in the form of The Mental Health Act (2001). This Act, which focuses on involuntary detentions and mechanisms for assuring standards in mental health care, brought Irish legislation in line with the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and the United Nations Principles for the Protection of Persons with Mental Illness (1981) (Walsh, 2002). Through the setting up of the Mental Health Commission and the Mental Health Review Tribunals, it guarantees an automatic and independent review of every admission order of persons involuntarily admitted to psychiatric centres and of any extensions of such orders. Finally, it abolishes the distinction in admission procedures and rights between public and private patients¹⁷. While the setting up of the necessary tribunals has been described as presenting a 'huge logistics challenge' (Kelly, 2004), and is not expected to be completed before the end of 2004 (Mental Health Commission, 2004a), it is hoped that the new legislation, when fully implemented, will provide greater civil safeguards to people diagnosed with a mental illness, both in relation to involuntary hospitalisation and to the quality of care that they will receive within these settings.

Forensic care

In Ireland, there is a single forensic psychiatric hospital, the Central Mental Hospital in Dundrum. This facility has been described as providing accommodation of "a totally unacceptable standard" (Mental Health Commission, 2004a: 29) and as being "totally unsuited for current usage, both on accommodation and humanitarian grounds" (Department of Health and Children, 2003b: 32). It is paramount that part of the profit from the planned sale of its grounds, which is expected to raise €70 million (O'Brien, 2004a), will be used to rectify this situation. At the moment the Central Mental Hospital has a capacity of 89 beds, of which only seven are reserved for female patients (O'Neill *et al.*, 2003), and of which three are for the specific use of female prisoners¹⁸. Again, this split resonates with the view that men who experience mental health problems, whether incarcerated or not, are perceived to be more dangerous than their female counterparts. In 2002, 107 patients were admitted to the Central Mental Hospital. The single most common diagnosis was schizophrenia (49 cases for all admission and 29 for first admissions) followed by drug dependence (19 cases for all admission and 14 for first admissions) (Daly and Walsh, 2003). No gender breakdown is provided for either admission or diagnosis.

The Central Mental Hospital has been described as "totally unsuited for current usage, both on accommodation and humanitarian grounds".

¹⁷ Under the previous act, two GP signatures were required for the involuntary admission of private patients while public patients could be admitted with just one GP signature (Personal Communication with Marina Duffy, Mental Health Commission, 15.09.2004).

¹⁸ Personal communication with Christina Quinlan, Lecturer and PhD Student, DCU, 10.08.2004.

O'Neill *et al.* (2003) in their needs assessment of long stay patients in forensic care highlighted the inverse correlation between rates of admission for the Central Mental Hospital and general psychiatric services at health board level. This relationship seems to indicate that many patients are unnecessarily placed in this institution due to the lack of more appropriate services in their locality. Furthermore, under-resourcing of local general psychiatric services was also deemed to create a barrier to discharge. Hence, improvements in the delivery of mental health services at local level are likely to contribute to a decrease of inappropriately placed patients and free up beds for those who truly require forensic care.


Rehabilitation services

"There has been little attention to the special rehabilitation needs of women" (Blehar and Norquist, 2002: 622), despite the fact that, as previously seen, rehabilitation is key to recovery (Groarke, 2003; Schizophrenia Ireland, 2003). Priority should be given to combating the social and economic isolation caused by mental illness (Prior, 1999). Housing has been considered as one of the most pressing need for women in or leaving mental health care (Morrow and Chappell, 1999), and housing solutions on offer should include short-term shelters and transitional houses, supported housing, family care homes, housing cooperatives and staffed residential facilities. Educational and employment components should also be included in rehabilitation services for women, in order to enable them to access adequate income for themselves and their families (Morrow and Chappell, 1999; Prior, 1999; Department of Health, 2002). The lack of rehabilitation services in Ireland has been noted by the Mental Health Commission (2004b; 2004a). The need for training programmes for service users to facilitate recovery once discharged was also one of the areas for improvement recently identified by a customer satisfaction survey for services at the acute mental health unit at Roscommon county hospital (Irish Medical News, 2004b). While individual services might be carrying out their own data collection, no general statistics in relation to these services are currently being collated.

Equity of access and care

The Irish health system has been recently characterised as the most inequitable in Europe (Finnegan, 2004), and mental health care is no different. Inequities in access and care are evident in Ireland both in geographical and social terms. In their report *The Stark Facts*, the Irish Psychiatric Association described a situation in which mental health resources have been developed in areas of greatest affluence, while the poorest concentration of resources has been in areas of greatest need (O'Keane *et al.*, 2003). The inequity of mental health services across the country has also been criticised by the Irish College of Psychiatrists (Browne, Arisa and Shepperd, 2004). Moreover, it has been documented that rural women also experience greater difficulties in accessing counselling and support services, as these are concentrated in urban areas (Batt and Nic Gabhainn, 2002).

Mental health resources have been developed in areas of greatest affluence rather than greatest need.



In social terms, the cost of primary care consultations for people on low wages who do not qualify for the medical card is a major deterrent from seeking help. To counteract this situation, eligibility criteria should be widened by increasing the income threshold (Women's Health Council, 2003b). If they do access care, as we have seen, women are less likely to receive specialised care and more likely to receive treatment for mental health problems within primary care, which is usually unsatisfactory and most often limited to the prescription of psychotropic drugs. Moreover, more women are being admitted to private hospitals, showing that the only women who do gain access to specialised treatment are those from higher socio-economic groups, i.e. those who can afford it to pay for it. On the other hand, lack of access to free medication through primary care acts as a deterrent against discharge from inpatient services (Coptly, 2004). Finally, women have been found to benefit from counselling and prefer it to complete reliance on psychotropic medication. However, free counselling is only available to women in specific groups and usually in relation to a traumatic life event, such as crisis pregnancy or abuse. Hence, counselling provision through referral at primary care level needs to be extended to ensure equity of access for all women experiencing mental health difficulties. The same applies to complementary therapies, whose cost is often prohibitive for women in low incomes.

The inequity of access and care needs to be urgently addressed and all mental health services should become available on an equitable basis. 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. Moreover, the evaluation of any mental health care system should be proofed against the nine grounds of discrimination laid out in the Equal Status Act (2000)¹⁹.


Intersectoral approach

Inter-ministerial cooperation is needed in order to truly safeguard mental health and provide effective services for those who require them. Many different government policies impact on mental health, such as social, legal, education, employment, housing and environmental policies. Hence, cooperation and coordination are needed in order to ensure that mental health is also considered when new policies are evaluated and health impact assessments are carried out. Special emphasis should also be placed on improving social capital and support social networks, as will be further discussed in relation to mental health promotion. Therefore, what is required is a multi-level, intersectoral approach combined with a gendered mental health policy. This should have a strong population health focus and gender-specific risk factor reduction strategies, as well as gender-sensitive services and the guarantee that these can be equitably accessed.

Data and Research Implications

The most pressing need in relation to research within Ireland is for the availability of data at community level covering both general mental health and the prevalence of mental health difficulties. In a recent EU report on mental health, general population surveys were described as "the only way to obtain information about population mental health and its access to care" (European Commission, 2004a). At the moment, only in-patient data are available through the report produced by the Health

¹⁹ An Equal Status Review is currently being piloted by the North Western Health Board in order to assess equality in service provision and highlight potential areas of discrimination in service delivery and for compliance with the Equal Status Act. Preliminary findings are expected in 2005 (personal communication with the NWHB Equality Officer, 18.08.2004).



Research Board on the Activities of Irish Psychiatric Services. This situation results in an incomplete picture that fails to capture the many manifestations of mental health problems, and to provide valuable information towards the planning of appropriate services. Without adequate information on the needs of the population, no accurate service provision plans can be put in place. Without comprehensive data on the people receiving, or who have received care in relation to mental health problems, no valid analysis on the effectiveness of different treatments and treatment settings can be carried out. Without this evidence-based evaluation, no improvement to current models of treatment and service provision will ever occur and people who are affected by mental health difficulties will continue to receive the same unsatisfactory quality of care as they do today. 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.

The most pressing need in relation to research within Ireland is for the availability of data at community level.

More broadly, the lack of gender-aware research in relation to mental illness has been widely documented, both in relation to efficacy of treatments and long-term outcomes (Blanch and Lubotsky Levin, 1998; Mowbray *et al.*, 1998; Blehar and Norquist, 2002). The design and analysis of clinical trials, as well as other therapeutic approaches, need to adopt a gendered perspective, if the effect of sex and gender on different clinical presentations, morbidity risks and response trajectories are to be understood (Merkatz, Clary and Harrison, 2002). In the USA, legislation requires that government-funded clinical trials include sufficient numbers of women to permit valid analysis of outcome data for gender difference (Blehar and Norquist, 2002). Similar provisions should be made in relation to all relevant research worldwide. Moreover, longitudinal research aimed at assessing how changes in social and household conditions affect mental health should also be undertaken (WHO, 2001a). In addition, quantitative surveys should be complemented with qualitative data, in order to document not only prevalence numbers, but also the lived experience of women affected by mental illness, how they cope with it, and what is helpful to them to improve their quality of life.

- Mental health services in Ireland are grossly under-funded and funding has decreased over the last ten years.
- Mental health care needs to adopt a gendered approach that is women-centred, holistic, community-based, client-driven and supported by advocacy services.
- Women in Ireland are treated primarily through primary care, however GPs receive very little specific training in mental health care. Nevertheless, there is evidence that counselling and psychosocial interventions delivered through general practice can be effective.
- Women prefer counselling to medication and counselling services should be available and accessible to all women experiencing mental health difficulties. Complementary therapies and self-help groups should also be easily accessible.
- Community care has been found to be effective for mental health care. The services should be expanded and provide appropriate treatment for women.
- Proper practical and financial support systems for carers need to be put in place in conjunction with the expansion of community care programmes.
- Women find inpatient settings particularly intimidating. Increased attention to patients' needs is required, alongside greater patient involvement and self-determination in treatment. The use of multidisciplinary teams is recommended.
- Full and speedy implementation of the Mental Health Act (2001) is required in order to safeguard patients' human rights in involuntary admissions.
- Forensic care provision is inadequate at the moment and admission to the Central Medical Hospital is often needed because of lack of appropriate provision locally.
- Rehabilitation services for women have been neglected and need to be expanded to include housing provision as well as educational and employment programmes.
- A high degree of inequity exists in Ireland in relation to access to and quality of care. Access to all services needs to be equitably distributed both in geographical and socio-economic terms.
- Intersectoral cooperation is needed as many policies affect mental health.
- A community prevalence survey is necessary in Ireland in order to gain a comprehensive view of mental health and mental health problems in the population.

6. Mental Health Promotion

The health of nations is currently measured in terms of their economy, or their Gross National Product. However, psychologists are now calling for the re-evaluation of this system and the introduction of well being indicators rather than economic ones, as these are more representative of the overall national social and financial environment (O'Boyle cited in Humphreys, 2004). In line with this broader approach to national well being, the importance of adopting a population health approach at structural level should also be underlined. In order to improve the general health of the whole population, this model looks at and acts upon the broad range of factors and conditions that have a strong influence on our health, including social factors such as gender, income and social status, social environment, education, employment and health services (Health Canada, 2004). Hence, it requires a co-ordinated and integrated, multi-sectoral policy (Department of Health and Children, 2001a), which does not focus solely on health services, but critically assesses the effect of the whole environment on a person's mental and physical well being. This all-encompassing model of healthcare would prove crucial in promoting and improving mental health at community level.

On an individual level, growing numbers of people are experiencing increasing levels of stress in the attempt to fulfil all of society's expectations of a 'successful life' (Mental Health Ireland, 2001). Moreover, our social worth is increasingly being assessed in terms of our economic contribution, both as producers and consumers. A reformulation of society's approach to the assessment of its members, with greater focus on their social and emotional contributions, would be beneficial. This approach would be particularly relevant to women, as they have traditionally been responsible for 'emotional' and 'caring work'. As gender roles shift and move away from their traditional mould, it will become more important for men, too. Within this revised framework, rather than merely focusing on economic factors, the emotions human being experience throughout their lives would receive greater attention and consideration. Hence, people affected by mental health difficulties and emotional distress would be less likely to be perceived as inadequate or to feel devalued.

In fact, the World Health Organisations claims that budgets for mental health will become rapidly depleted if funding is focused only on curative treatment and care (WHO, 2001a). A commitment to mental health promotion therefore is paramount in order to improve the general mental well being of the population. Mental health promotion covers a variety of strategies, with individual as well as community and social foci. On an individual level, all women should be helped to develop coping skills and improve their self-esteem, so that they might be better equipped to negotiate stressful life events and transitions. However, as many of the stressors in women's lives derive from their social circumstances, and especially the strain caused by their multiple roles, preventive strategies aimed at the societal level are the most critical for the promotion of their mental health. As psychiatric morbidity and hospitalisation are both inversely related to low socio-economic position, and women consistently experience greater social disadvantage than men, anti-poverty programmes and strategies to improve housing and employment will have a positive impact on women's mental health (Prior, 1999). Multi-sectoral action involving many other government departments, such as education, environment, transport, as well as legal policies and the criminal justice system will also be relevant.

Moreover, promotion strategies should involve social and community services as well as NGOs and community-based organisations (WHO, 2001c, a; Department of Health, 2002).

Worldwide, three main factors that contribute to the prevention of mental illness and especially depression in women have been identified:

- 1) Autonomy/independence.
- 2) Financial security.
- 3) Psychosocial supports (WHO, 2004).

In the report *Women's Mental Health: an evidence based review*, the WHO lists six objectives for the effective promotion of women's mental health:

- to assist women to increase control over their lives, and especially to reduce any type of devaluation or discrimination of women's status in society;
- to decrease women's exposure to risk factors through education and legislation that will improve women's material well being, status and available life choices;
- to involve women in decision-making, not just in health treatments but also in other aspects of their lives more broadly;
- to ensure that any treatment towards women's mental health is obtained on the basis of informed consent and guarantees dignity and confidentiality;
- to strengthen social networks and communities to enable them to provide practical and emotional support;
- to preserve and strengthen social capital, as a public good, and reduce income inequalities (2000).

All of the above recommendations are applicable to an Irish setting. Female gender is still a predictor of lower status and lower pay in Ireland (United Nations Development Programme, 2004). In the first national survey of Irish employees, women were found to experience higher levels of work stress than men, even though their level of work pressure was lower (O'Connell *et al.*, 2004). These findings were taken to point to women's greater responsibility for caring and domestic work, as well as the fact that they have less control and discretion in the workplace due to the kind of positions and types of sectors in which they are primarily employed. Hence, the introduction and implementation of family-friendly and work-life balance policies alongside the promotion of gender equality in education and employment, and the provision of adequate childcare facilities will be of great benefit in reducing work-related stress for women.

Women experience higher levels of work-related stress than men.

Moreover, disadvantage needs to be tackled, and social inequalities within service provision rectified. A serious commitment to combating violence against women also needs to be undertaken through appropriate prevention strategies both in the social and legal sphere. The inclusion of women's mental well-being in the National Health Promotion Strategy is, therefore, welcome (Department of Health and Children, 2000). The Strategy lists two objectives under this heading: to promote positive mental

health, especially at vulnerable times in women's lives; and to develop women-friendly approaches designed to enable more active participation of women in the management of their health. Without community epidemiological data it is impossible to assess whether these goals have been achieved. However, the consistently high numbers of women presenting with mental health difficulties, and especially depression, at primary and secondary care levels would indicate that further work is needed and more effective strategies are required.

One final objective for mental health promotion lies in the field of education and public awareness. All people affected by mental illness suffer from a high level of stigma, and thus might experience social rejection, and be denied equal participation in family life and employment. Moreover, stigma has a detrimental effect on a person's recovery, ability to access services, and the type of treatment and support they receive (WHO, 2001b). A recent survey of public attitudes to disability in Ireland found that people with mental health difficulties experience even more discriminatory attitudes than those with other types of physical or intellectual disability (National Disability Authority, 2002). The study found prevalent negative attitudes towards people with mental health difficulties and their right to having fulfilling relationships, children, and equal opportunities at work. In another survey, nearly one in five respondents felt that people with mental illness pose a danger, and one in ten felt that the provision of mental health care within their neighbourhood would pose a threat to safety (Mental Health Ireland, 2003).

People with mental health difficulties experience even more discriminatory attitudes than those with other types of physical or intellectual disability.

The stigma associated with mental illness can be reduced by increasing awareness and understanding of mental health issues in society, for instance through mass media awareness campaigns and school programmes, such as the Social, Personal, and Health Education curriculum at primary and secondary level, and the Civic, Social, and Political Education one at secondary level²⁰. Support and treatment services that enable people affected by a mental illness to participate fully in society, such as service provision through primary care, community care, and within generalised hospital settings, should also be promoted and encouraged. Finally, ensuring that people who experience mental health problems are not discriminated against in the workplace and in access to health and social community services must be a priority. It is hoped that the recently published Disability and Comhairle Bills (2004) will bring positive developments towards ensuring that people with mental health problems are fully integrated within society and have legal recourse against the injustice of discriminatory practices.

- The three main factors that contribute to the prevention of mental health problems, and especially depression in women are: autonomy/independence, financial security, and psychosocial supports.
- In Ireland, family-friendly policies need to be introduced at work and adequate childcare provision introduced.
- Disadvantage needs to be tackled.
- The stigma linked with mental illness needs to be reduced in order to encourage access to services and promote recovery.

²⁰ Relevant curricula should also be developed and expanded in all five sectors of education: early, primary, secondary, higher, and lifelong learning.

7. Summary and Conclusion: Towards improved mental health care

Mental health problems are common in Ireland, with increasing numbers of people experiencing growing levels of stress (Mental Health Ireland, 2001), ten per cent of the population estimated to be affected by depression (Department of Health and Children, 2001b), and high numbers of admissions to psychiatric hospitals (Mental Health Commission, 2004b). Nevertheless, policies to promote mental health and improve mental health services are often neglected by government, with greater emphasis placed on physical health and most of the health budget allocated to it.

Through this report, the Women's Health Council wished to emphasise the need to correct this situation and advocate a gendered approach to mental health diagnosis, treatment, and service provision. Both international and national data show that women and men are affected by different mental health problems, and experience them in different ways. Women predominantly experience anxiety and "depression disorders", while men are most commonly affected by "behavioural disorders" and drug abuse (Busfield, 1996; Gomel, 1997; Prior, 1999; Astbury and Cabral, 2000; WHO, 2001a; Busfield, 2002; Kornstein and Clayton, 2002). Gender variations have also been observed in the manifestations of mental illnesses, such as schizophrenia or bipolar depression, which affect women and men in equal proportions. Numerous reasons have been proposed for this gender diversity, including biological, psychological and social theories. For women, however, it is primarily their lower status in society, as well as the strain brought upon by the many roles that they perform in society, what has been called the triple burden of productive, reproductive and caring work (WHO, 2001a), that have been found to cause the onset of mental illness. Hence, the improvement of women's position in society alongside a fairer distribution of caring responsibilities will go a long way in improving their mental health and reducing their risk of experiencing mental illness.

Moreover, the treatment of mental illness is influenced by gender just as much as its diagnosis. Because of the nature of their most common mental health difficulties, women are usually treated within primary care settings through the use of psychotropic medication, and are less likely to be referred to specialist services. On the other hand, men tend to defer seeking treatment until their difficulties have become such that hospitalisation might be required. However, the use of psychiatric admission might also reflect a widespread perception of men as more dangerous and in need of control. Hence, while the treatment they receive for their difficulties is gendered, it is not based on evidence but on societal expectations and stereotypes. What is needed instead is a clear understanding of the effect of gender, among other social determinants, on mental health and mental illness from diagnosis, to treatment and recovery. Women and men would both benefit from such an approach.

While the need for a gender-sensitive approach is substantiated by the evidence presented, further analysis in an Irish context is hindered by the dearth of data available. The paucity and nature of data currently being gathered significantly limits the ability of service providers to plan effectively for the population's needs. Moreover, few evaluations of treatment pertinent to the physical and social determinants of health are possible, as statistics are rarely adequately disaggregated.

Nevertheless, what is widely documented is that at the present time mental health services do not provide satisfactory care for people affected by mental health difficulties, and especially for women. An integrated model of care for women, which would greatly improve the quality of care that they receive, is advocated. This model would be underpinned by a gendered analysis of the causes and manifestations of mental health problems, with special attention to women's greater use of primary care as well as their preference for counselling, and receiving care in the community. However, adequate, gender-conscious inpatient settings are also required. In summary, in order to be effective, a model of care for women needs to be:

- woman-centred, in which the specific mental health concerns and life priorities of women are taken into account in the design and implementation of their treatment;
- holistic, in which attention is paid to women's social circumstances as well as their physical health;
- community-based, in which primary care and community systems are backed by inpatient psychiatric beds when necessary;
- person-driven; in which current and past service users' views are sought and considered for the planning and implementation of services at every level of care provision; and
- supported by advocacy services championing the concerns of women mental health care consumers.

Special consideration should be also given to equity of access and treatment, especially for particular groups of marginalized women.

Furthermore, the above approach needs to be informed by evidence. Increased access to counselling has been widely recommended as beneficial in the treatment of mental health problems in women. A recent research study by The Women's Health Council found that women in Ireland also wished for increased availability of counselling services (Batt and Nic Gabhainn, 2002). At primary level, mental health training should be delivered to general practitioners, with special focus on counselling and psychosocial interventions, which have been found to be effective (Bower *et al.*, 2004; Huibers *et al.*, 2004). At secondary care level, the use of community approaches has been widely advocated. Community care allows women to continue the performance of their social roles as partners and parents to a greater extent than inpatient care; reduces social isolation, and has also been found to be less stigmatising. Due to the high prevalence of physical and sexual violence experienced by women affected by mental health problems, the provision of women-only facilities within care is also extremely important, both in community and hospital settings. In addition, the provision of educational and employment programmes for women experiencing mental health problems is paramount to reduce their exposure to disadvantage and ensure a positive treatment outcome. As disadvantage is often the cause of poor mental health in women, tackling poverty and ensuring adequate provision of social services would also reduce the risk of relapse.

In order to provide an improved mental health care sector, adequate funding is also going to be paramount. At the moment, mental health services in Ireland are grossly under-funded, receiving less than seven per cent of the health care budget, despite the fact that mental health disability

contributes approximately 20 per cent of total health related disability (Mental Health Commission, 2004a). Hence, the Women's Health Council would strongly recommend that the announced sale of land from psychiatric hospitals holdings will be ring-fenced towards the provision of mental health services in the community and used effectively and equitably.

In conclusion, gender and all its implications and ramifications have to be considered in every aspect of service provision to women with mental illnesses, and taken into account from diagnosis, to assessment, planning and delivery of treatment and rehabilitation as well as evaluation of outcomes (Mowbray *et al.*, 1998). Moreover, the adoption of a 'gender lens' (Morrow and Chappell, 1999) will highlight the fact that it is never likely to be adequate to respond in purely clinical ways to mental health problems that originate partly or wholly in women's lived experiences, from their lower social status, to their greater likelihood of stressful life events (Johnson and Buszewicz, 1996a). Increased multi-sectoral collaboration must also be promoted, as mental health is affected by many government policies, including, for instance, social services, education, employment, and housing.

Finally, the Women's Health Council hopes that the evidence presented in this position paper will inform the work of the Mental Health Commission, the Expert Group on Mental Health policy, and people working in mental health care for men and women. Moreover, the Council wishes to encourage policy makers and service providers in other relevant areas to be aware of the effect that current social, educational and employment policies, for instance, have on women's mental well being.

Recommendations

- A gendered approach must be adopted in order to understand and treat mental health problems effectively.
- More information on mental health problems at population level needs to be gathered and collated, including a longitudinal community survey, and a survey of mental health care in general practice.
- Improved quality of care needs to be delivered, with increased equity of access. Gender awareness is needed in order to achieve both of these aims.

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Appendix I: Common Mental Health Problems for Women

Anxiety

One of the mental health issues to which women appear to be particularly prone is anxiety. The term anxiety refers to an unpleasant and overriding mental tension, and "anxiety disorders" include phobias, "panic disorder", "post-traumatic stress disorder", and "obsessive-compulsive disorder". Anxiety-related difficulties are the most common mental health problem, occurring in one in ten people in the general population (Robbins, Helzer and Weissman, 1984; Bland, Orn and Newman, 1988). In American community surveys, almost a third of females were found to meet lifetime criteria for an "anxiety disorder" (Piggott, 2002). Worldwide, the number of women who develop anxiety-related problems, however, is far greater than men (Weissman *et al.*, 1984; Breslau, Schultz and Peterson, 1995; Piggott, 2002). A history of childhood trauma is associated with an increased risk for subsequent anxiety in both sexes. However, females have been found to be particularly sensitive to adverse conditions associated with childhood abuse (Piggott, 2002). Studies have shown that anxiety often goes hand in hand with depression, and that anxiety symptoms often precede depressive symptoms (Alloy *et al.*, 1990) and predate the onset of major depression (Angst *et al.*, 1990).

Depression

Gender difference in depression is one of the most robust findings in psychiatric epidemiology (WHO, 2001a), and women have been diagnosed to be affected by this illness at approximately twice the rate of men worldwide (Kohen, 2000; Hyman, 2001; WHO, 2001a; Kornstein and Wojcik, 2002; Stewart, Gucciardi and Grace, 2004). In a report by Astbury and Cabral for the WHO, depression has been described "not only as the most frequently encountered women's mental health problem, but also as the most important women's health problem overall" (2000: 31). Symptoms of depression include feelings of sadness and hopelessness, diminished interest and pleasure, changes in weight and in sleep patterns, chronic fatigue, feelings of worthlessness or guilt and difficulty concentrating or thinking (Stewart, Gucciardi and Grace, 2004). Moreover, depression is often linked with physical health problems, both in terms of cause and effect. Its causes have already been explored in detail and, as seen, while some depression among women may be in part explained by biological factors, it has been more strongly linked with gender-specific socialisation and coping styles, and most often with the stress women experience because of conflicting multiple roles, lack of control of their fertility, violence, low income, low status and self esteem. The significance of stressful life events, and especially childhood and adult physical and sexual violence has also been noted. In addition, social and economic disadvantage have been found to be strong predictors of depression. As women consistently experience greater levels of disadvantage, they are therefore increasingly at risk of developing this illness than men. Moreover, in disadvantaged situations, greater financial and practical barriers exist for women in terms of access to services (Glied, McCormack and Neufeld, 2003). The importance of equitable access to services is, therefore, of paramount importance in order to help minimise and treat depression.

Research conducted by the Health Research Board on psychiatric admission rates in the Republic of Ireland has consistently found higher rates of admission for "depressive disorders" among women, with a rate of 293.2 per 100,000 people in 2002, compared to 216.8 for men (Daly and Walsh, 2003). However, as these figures only relate to inpatient care, they are bound to take into account primarily severe depressive episodes, while most depression, on the other hand, is treated through primary care. The fact that women are still over-represented in this category signifies that they are affected by depression to a far greater extent than men, all other factors being equal. In her study of gender differences in mental health in Ireland, Cleary (1997) found high levels of depression among a random sample of 75 women in a Dublin City community. She found that over half the sample had previously sought treatment for psychological difficulties, and 28 per cent were receiving treatment at the time of the study. Moreover, women who were experiencing depression showed a history of significant disadvantage and deprivation in their background. In addition, a recent study showed that women in Dublin were at a higher risk of depression than women living in other European cities, with up to one third of Dublin women found to be depressed at a point in time (Connolly, 2003). Again, disadvantage was put forward as an explanation for this finding, and the promotion of social, healthcare and political networks advocated as a strategy to ameliorate the situation.

Postnatal Depression

A literature review carried out on behalf of the Women's Health Council (Ní Riain, 2001), found that up to 30 per cent of depression episodes in women start as a result of a reproductive event, such as pregnancy, childbirth, infertility, menopause, or oral contraceptive exposure. Postnatal depression has received particular attention because of its potentially damaging effects on child health and development. Rates of postnatal depression have been reported to be between 6.8 per cent and 16.5 per cent in adult women, and up to 26 per cent in adolescent mothers during the first postpartum year (Arnold *et al.*, 2002). Psychosocial issues, including unwanted or unplanned pregnancies, coping difficulties, marital/couple discord, infant medical problems, lack of social support, and stressful life events during pregnancy, have all been found to increase the risk of postnatal depression (Arnold *et al.*, 2002). The chronic stressors of poverty have also been found to constitute a further risk factor for women in lower socio-economic status, and recent research showed that income levels directly affect depressive symptoms in women during the first three years after childbirth (Dearing, Beck and McCartney, 2004).

Postnatal depression is the most common form of mental illness that affects Irish mothers. Estimates of its incidence vary between 10 per cent (McCarthy, 1998) and 15 per cent (Eastern Health Board, 1998), with 24 admissions to Irish psychiatric hospitals and units in 2001 for postnatal depression²¹. Ireland's maternity services are inadequately resourced to deal with postnatal depression. Although there are consultant psychiatric attachments to the three main Dublin maternity hospitals, and a Mental Health Liaison Midwife was appointed at The Rotunda Hospital in 2001, there are very few resources outside of the Dublin region. Furthermore, there are no specialist teams, no Mother & Baby Units, and little or no training offered in this area (McCarthy, 1998). Hence, awareness of the incidence of postnatal depression needs to be raised among both health professionals and women.

21 Personal communications with Antoinette Daly, Mental Health Research Division, Health Research Board. 15.12.2003

Information on this mental health problem could be delivered at antenatal classes, and sensitive and appropriate clinical screening should be introduced during the antenatal period and postnatal period. Again, social provisions to reduce the effect of disadvantage for mothers should also prove crucial in reducing the rates of postnatal depression²².

Eating Disorders

The term eating disorders refers to a group of conditions characterised by severe disturbances in eating, coupled with emotional and psychological distress and the resulting physical consequences (Bodywhys, 2004a). About three to eight per cent of women have been estimated to have some type of eating disorder (Tylka and Subich, 2004), and eating disorders appear to have reached epidemic proportions in Western societies (Orbach, 1993). Women are primarily affected by eating disorders, as 95-97 per cent of patients with anorexia nervosa and 80 per cent of patients with bulimia are females. Untreated anorexia nervosa has been associated with the highest mortality rate of any other psychiatric condition (Powers, 2002). Women's greater susceptibility has been explained in terms of their physiology (e.g. their body's greater fat content), but has been linked to a greater extent to cultural pressures to adhere to the equation of beauty with thinness (Grogan, 2000; Malson, 2000; Gucciardi *et al.*, 2004). Dieting has been identified as one of the major risk factors, and the expansion of the diet industry is testimony to women's preoccupation with their bodies. In the most recent SLÁN report, women were more likely to report being on a weight reducing diet than men (Kelleher *et al.*, 2003). Moreover, such preoccupation is now starting at earlier stages, that is, during adolescence and even childhood (Orbach, 2001). A study of Dublin teenage girls found that 59 per cent were not happy with their weight and more than two thirds of them had previously tried to lose weight, with dieting being the most commonly used method (Ryan, Gibney and Flynn, 1998).

No consensus has yet been reached on the best model of treatment of eating disorders (Kohen, 2000). While attention needs to be directed towards the medical complications arising from them, such as osteoporosis, cardiac problems and renal abnormalities, in line with an integrated model of treatment, psychosocial issues cannot be ignored. Hence, a multidisciplinary approach should be preferred (Bodywhys, 2004b), and therapy is recommended (Orbach, 2001). While The Mental Health Commission in Ireland highlighted the need for specialist services for eating disorders, it seemed to focus primarily on medical issues, rather than emphasising the need for a therapeutic approach (Mental Health Commission, 2004a). Meanwhile, the North Eastern Health Board has sent a number of children to the UK for treatment as it believes that no equivalent services are available in this country (Irish Medical News, 2004a). The Department of Health and Children listed a report on services for eating disorders in its most recent strategy (2001b), raising the hope that further and much needed developments will take place in the near future.

Parasuicide

The rates for attempted suicide (or parasuicide) are commonly higher for women than for men (Prior, 1999; WHO, 2001a). Men are more successful in taking their own lives, whereas more women attempt to do so (Greenberger, 2001). A recent literature review by The Women's Health Council on *Women and Parasuicide* found that the greater rate of attempted suicide among women is likely to be related to the methods chosen (2003a). Women are more likely to attempt suicide by overdosing on drugs, a method whose consequences can be treated medically, giving some margin for rescue. On the other hand, men use more violent methods, for example hanging, which would increase their chances of completing the suicide.

The differing rates of parasuicide among men and women in Ireland should be noted. While men have a higher rate of completed suicide, in line with European data, research has shown that in general women have higher rates of attempted suicide. The latest figures from the National Parasuicide Registry indicate that the female rate of parasuicide is higher than the male rate in every single Health Board area (National Suicide Research Foundation, 2003). In the North Western Health Board, the female rate is higher than the male by 12 per cent. In turn, this was higher in the South Eastern Health Board by 45 per cent, and by 47 per cent in the Southern Health Board. The highest number of recorded attempts occurred for women in the 15 to 19 year old range. Moreover, compared to boys treated in hospital after a suicide attempt, there were two to three times as many girls aged 15 to 19 and 10 to 14, respectively (Corcoran *et al.*, 2004). Based on these results, Corcoran *et al.* (2004) calculated that each year in Ireland one in every 200 16-year old girls are treated in hospital following a suicide attempt. These figures are very worrying and greater attention will need to be directed towards understanding and ameliorating the problems facing Irish teenage girls, given that these are of a high enough magnitude to make them attempt to take their lives.

Appendix II: Vulnerable Groups of Women

While there is a commonality of experience of disadvantage shared by all women on the grounds of gender, specific groups of women experience significant additional disadvantage (Women's Health Council, 2003b). For instance, members of different social groups face multiple discriminations based on their other social characteristics, such as their ethnicity, age or sexual orientation. Hence, considerable variation has been found among women, depending on their class and ethnicity in the level and type of mental health problem (Busfield, 2002). Groups that are known to experience particular disadvantage in relation to mental health, as well as physical health in most cases, will be examined in more detail in the sections below.

Lone Mothers

Single motherhood has been associated with a high rate of any mental health difficulty in women, (Sachs-Ericsson and Ciarlo, 2000; MacLean, Glynn and Ansara, 2004) and especially depression (Kornstein and Wojcik, 2002; Stewart, Gucciardi and Grace, 2004). A Canadian study revealed that single motherhood status was the strongest independent predictor of mental health morbidity and utilisation of mental health services. Low income was the next strongest predictor. This particular factor is, clearly, highly related to single motherhood status (WHO, 2001a). Lack of economic resources and the absence of a co-parent to share even a part of the workload result in particularly stressful lives for single mothers (Lasswell, 2002). In the UK, lone mothers have been found to have particularly poor mental health; even when household income, employment status and occupation are taken into account (Department of Health, 2002). Morrow and Chappell have described the concerns of single mothers in relation to mental health as particularly acute, and special attention should be given to guarantee them access to mental health services (1999). The importance of equitable access and the provision of childcare facilities, as well educational and employment programmes linked to treatment cannot be overemphasised.

While prevalence rates for mental health problems among women of lone parent status are unavailable in Ireland, the fact that single parent status has been found to increase the risk of disadvantage and social exclusion (OPEN, 2004) would lead to an assumption of high prevalence of mental distress among single mothers. In fact, a recent study on well-being in Irish families found that one-parent single families have a negative effect on mothers, who tend to have lower levels of psychological well-being than other parents (McKeown, Pratschke and Haase, 2003). While support groups and access to counselling would undoubtedly prove beneficial, it is the reduction of their exposure to disadvantage that would be critical to the reduction of their mental distress. Hence, anti-poverty strategies as well as educational and employment schemes for single mothers seem to offer the best prevention and treatment model. The provision of adequate affordable childcare facilities within such programmes would be crucial to their accessibility and effectiveness.

Women from Ethnic Minorities

The mental health problems of ethnic minority women tend to be particularly related to such external factors as racism, sexism, poverty, sub-standard housing and as well as discrimination and the fear of racial attacks (Al-Mateen *et al.*, 1998; Holmshaw and Hillier, 2000; Kohen, 2000). Moreover, in their

role as primary carers and cultural mediators for the whole family, women are also expected to uphold cultural traditions and gender roles, and have been found to experience a disproportionate amount of stress (Neufeld *et al.*, 2002). Hence, women from ethnic minorities are doubly discriminated against, that is, both by their gender and their ethnicity.

Ethnic minority women have been found to show reluctance to access mental health services, which are predominantly staffed by males from the majority population (Padgett *et al.*, 1998). Therefore, when they do so, women from ethnic minorities need to be treated in a culturally aware and sensitive manner. Cultural norms may complicate the assessment and treatment process, and ultimately affect the outcome (Al-Mateen *et al.*, 1998; British Medical Association, 2002). Al Mateen *et al.*, (op. cit) explain that pitfalls in diagnosis may result from linguistic difficulties, lack of corresponding vocabulary to describe mood states in different languages, cultural permission to focus only on physical symptoms and/or confounding acculturation difficulties. During treatment, choice of gender of the medical professional should be provided (British Medical Association, 2002), and within inpatient settings, special attention should be given to culturally appropriate food, personal hygiene and spiritual requirements (Department of Health, 2002).

Currently, very little data is available on the mental health of ethnic minorities at community level in Ireland. Moreover, neither inpatient facilities nor community services disaggregate their admission information by ethnicity. While returning Irish nationals still account for over a third of all immigration into Ireland (Central Statistics Office, 2004), people of other nationalities have been increasingly migrating to the Republic (NCCRI, 2002; Immigrant Council of Ireland, 2003), with Asian, African and Eastern European communities now well established throughout the country and especially in the Dublin area. Hence, information on ethnic identity will prove vital in order to monitor the incidence of mental health problems and provide appropriate services for newly arrived as well as indigenous ethnic minorities.

Traveller Women

A women's health survey carried out in 1997 showed that 34 per cent of Traveller women were affected by long term depression, compared to approx nine per cent of settled population (Pavee Point, 1999). This high prevalence can be directly linked to the high level of disadvantage and discrimination experienced by the Travelling community (Pavee Point, 1995). Access to mental health services is also particularly problematic for Traveller women, as mental health care is uniquely tied to a specific catchment area, based on a residential address²³. Hence, there are great bureaucratic difficulties in accessing services when an address cannot be provided or when travelling across different catchment areas. Reform of this administrative set-up would go a long way towards improving accessibility to services for Traveller women. Among the actions proposed in the National Strategy for Traveller Health (Department of Health and Children, 2002), two were directed to mental health care provision: the establishment of formal links between community psychiatric services and Traveller organisations in each Health Board area to facilitate early intervention; and the establishment of a national working group to explore culturally appropriate models of mental health services for Travellers. However, these

²³ A catchment area refers to the area traditionally served by a district mental hospital. In many cases catchment areas correspond with county boundaries. There are 44 catchment areas nationally, each covering between 40,000 and 250,000 population.

actions have not been implemented to date. Nevertheless, a Traveller Health Study to inform appropriate actions required in the area of Travellers' health, including mental health, is currently being designed by the Department of Health²⁴.

Women from other Ethnic Minorities

Migration has been described as a crisis event (Al-Mateen *et al.*, 1998), and found to cause mental distress (Bhugra, 2004). Migration normally involves getting used to a new culture and a new language. Moreover, it often means working in low-paying jobs and living in cramped or substandard housing. All these experiences can cause tremendous strain, especially on women. Furthermore, the traditional support systems on which one used to rely on are no longer available, and new ones not yet formed or accessible. Immigrant women who are also asylum seekers and refugees experience the additional burdens of memories of traumatic experiences in their country of origin and the prospect of an insecure future in their host country. Psychological distress is common among asylum seekers, particularly among those who have experienced torture and/or rape. Marked signs of anxiety, depression, guilt and shame ensuing as result of previous and current situation have also been documented (British Medical Association, 2002). A recent study on the health and health needs of minority ethnic communities in Ireland (Cairde, 2003) highlighted that insecure legal status, forced inactivity, lack of adequate and suitable financial resources and living conditions, and lack of family and communal support structures constitute some of the more significant causes of stress, anxiety and depression among ethnic minorities. Over 80 per cent of the research participants were found to be affected by stress and symptoms of depression.

Services in Ireland are poorly equipped to deal with the stress experienced by migrants (Kelly, 2004; National Disability Authority, 2004), and catering for their needs has been identified as one of the major challenges for the Irish mental health system (Kelly, 2004; Mental Health Commission, 2004a). Apart from access to information and services, the need to provide for appropriate interpreting has been raised (ICCL Women's Committee, 2000). At present in Ireland interpreters do not have to be qualified, and the use of family or friends is frequent, despite being discouraged in professional guidelines (British Medical Association, 2002). These not only recommend the use of professionally qualified interpreters, but also advocate the use of the same interpreter throughout all consultations, in order to aid the building of trust. The use of gender, political and cultural awareness in the choice of interpreter is also needed (British Medical Association, 2002). The unsatisfactory approach currently used in Irish services can result in poor communication of the patient's symptoms, but also, more insidiously, in the interpreter's own views of the patient's situation and condition influencing the diagnostic and treatment process²⁵. Access by new asylum seekers to a refugee community group has been found to reduce the severity and likelihood of mental illness (British Medical Association, 2002). In light of such findings, the government policy of dispersal should be reconsidered. Finally, members of ethnic communities should be encouraged to act as advocates and develop counselling skills (British Medical Association, 2002).

24 Personal communication with Mary O'Reilly, Travellers Health Policy Unit, 05.10.2004.

25 The Irish Translators and Interpreters' Association has called for an end to this situation, and a new Postgraduate Certificate in Community Interpreting is now available in Dublin City University (Personal Communication, Mary Phelan, Course Director, DCU, 06.08.2004).

Women with Disabilities

Lack of resources is an issue of particular relevance for this group, as recent data shows that the risk of falling below the 60 per cent poverty line is significant for a household headed by a person with a disability. Moreover, this risk has increased from 30 per cent in 1994 to 54 per cent in 2000 (Combat Poverty Agency, 2002). This situation may be explained by the additional costs of living with a disability, including transport, housing modifications, and medical care, as well as the dearth of employment opportunities. In relation to the mental health repercussions of living with a disability, depression is one of the most frequently mentioned secondary conditions among women with disabilities (Thierry, 1998). A recent study carried out in Northern Ireland, found that women with disabilities in their sample were more likely to be depressed than their male counterparts (24% vs. 17%) (Breslin, 2003). Moreover, women with disabilities were generally also more likely to have experienced a lot or a great deal of stress compared to men (44% vs. 34%) and would have liked access to counselling services.

According to Canadian research on their mental care needs, it is counterproductive to deal with the physical and mental health issues of women with disability separately (Morrow and Chappell, 1999). In some instances, physical problems were considered to be due to their mental health challenges, especially in relation to medication. On the other hand, women felt that physical ailments were often misdiagnosed as mental illnesses. A holistic approach to care, merging physical and mental concerns, was felt to be more beneficial and effective. Moreover, the issue of physical access was also one of grave concern for women with disabilities in this study. In general, mental health services and their staff were found not to be equipped to deal with the access challenges of physical disability. The issue of violence against women also needs to be mentioned. Violence against women with a disability is more hidden than that against women without disabilities. In addition, refuges and other support services for women who experience violence are frequently not adequately adapted to suit the needs of women with disabilities.

Finally, it is important to highlight the lack of services for women with an intellectual disability. Services in this area have been found to be particularly under-resourced (Mental Health Commission, 2004b; National Disability Authority, 2004). The traditional practice of care of intellectually disabled patients in long-stay psychiatric facilities is inappropriate and the Inspectorate of Mental Hospitals has been recommending their transfer to appropriate services centres, where they may be able to access specialised care, for a number of years now (Department of Health and Children, 2003c).

Lesbian Women

International research findings suggest that lesbian women have higher rates of risk factors that put them at increased danger for poor mental health, compared with heterosexual women. For example, lesbians have been found to have higher use of mental health services, higher rates of "mood disorders", anxiety and alcohol and substance dependence (Klinger, 1998; Boschert, 2001; Cochran, Sullivan and Mays, 2003; Meyer, 2003). It is speculated in the literature that factors such as living in a largely homophobic society, internalised homophobia, fear of coming out, discrimination experiences,

and the chronic stress associated with being a member of a stigmatised minority group may be responsible for the poorer mental health often experienced by lesbian women (Klinger, 1998; Meyer, 2003). Suicidal ideation is a common manifestation of this poorer mental health, which has been found to be particularly common among younger lesbians (Bagley and D'Augelli, 2000; Matthews *et al.*, 2002). Klinger reports that in community-based American samples of lesbian and gay youth, 20 to 42 per cent attempted suicide, often more than once (1998). Despite this higher prevalence of mental health problems, lesbian women have been reluctant to approach mental health services in order to avoid being pathologised as deviant (Morrow and Chappell, 1999). Klinger again recommends that mental health professionals treating women should not make any assumptions on their sexual orientation, and found that treatment is most effective when therapists have both factual knowledge of lesbian issues and development, as well as self-knowledge about their own attitudes towards homosexuality (1998).

There is a dearth of knowledge surrounding lesbians' health and health-seeking behaviour in the Irish context. The Combat Poverty Agency's report on poverty among lesbians and gay men showed that 'discrimination and prejudice result in lesbians and gay men being disadvantaged and excluded from full participation in society' (Gay & Lesbian Equality Network and Nexus Research Co-operative, 1995). Almost one-third of those who took part in the study reported being effectively homeless at some stage in their lives. Many experienced bullying, harassment in the workplace or violence, reporting that their job opportunities were severely narrowed through fear of discrimination. Due to the increasing numbers of young people attempting suicide, the National Disability Authority has recently called for the monitoring of the link between suicide and sexual orientation (2004).

Older Women

Women over the age of 75 have been found to have the highest rates of any mental illness in American Epidemiological Surveys (Padgett, Burns and Grua, 1998). When "organic disorders", such as dementia or Alzheimer's disease are excluded, rates dropped significantly. However, older women's rates remained higher than those for men. While there are no gender differences in the prevalence of "organic disorders", older women present with higher rates of depressive symptoms (Holroyd, 1998). This pattern can be associated with women's increased risk of poverty, a greater likelihood of widowhood and of living alone, and societal devaluation, i.e. what have been called the converging effects of ageism and sexism (Padgett, Burns and Grua, 1998).

Estimates of the prevalence of mental illness among institutionalised elderly persons residing in nursing homes have indicated a prevalence rate of 65 per cent, much higher than for elderly people in non-residential settings. As women generally comprise the overwhelming majority of nursing home residents, it is imperative that their needs be appropriately highlighted and addressed within such settings. Despite the fact that psychological therapies have been found to be as effective in older people as in younger people (Burns, Dening and Baldwin, 2001), studies have shown that older women are more likely to be over-medicalised and receive ECT (Electro-convulsive therapy) more often than

younger or male patients (Morrow and Chappell, 1999). Hence, sexism and ageism persist in the treatment of elderly women as much as in the causes for their mental distress.

In a 1996 study it was estimated that 20 to 25 per cent of older Irish people have a mental health difficulty of some severity at any one time. Roughly five per cent of people over 65 years of age experience some form of dementia and a further 15 to 20 per cent are affected by other mental health problems, such as depression and anxiety (Keogh and Roche, 1996). In 2002, more females than males over the age of 65 were admitted for inpatient treatment in Ireland (1078 vs. 887). The main diagnoses for the 65 years of age or over were "depressive disorders" (1312 admitted), schizophrenia (464 admitted) and mania (400 admitted) (Daly and Walsh, 2003). Unfortunately, these data are not disaggregated by gender. Taking into account that people over 65 will comprise over 14 per cent of the Irish population by 2011 (Fahey, 1995), the provision of adequate health care for the ageing population has been identified as one of the biggest challenges for the Irish mental health services (Kelly, 2004), as geriatric psychiatry is one of the areas in which services are most underdeveloped (Mental Health Commission, 2004a).

Women Living in Rural Areas

Rural life has been found to have negative mental health repercussions worldwide, due to the social and financial disadvantage it often entails, especially for women (WHO, 2001d). Depression rates among rural women have been reported to be more than twice those of the general population (Hauenstein and Boyd, 1994 cited in WHO, 2001d). An American study found that rural women expressed feelings of inadequacy and powerlessness and experienced anxiety and lower self-esteem than their urban counterparts as a result of traditional rural family values and sex-role conflicts, coupled with isolation and loneliness (Hughes Gaston, 2001). However, cultural values which emphasised physical strength, productivity and vitality prevented the rural women in this study from talking about their distress or seeking help. Moreover, even when help is sought, rural women experience greater difficulties in accessing services, as clinical resources and expertise are usually concentrated in urban areas.

A recent study on the provision of counselling services for Irish women carried out on behalf of the Women's Health Council found that the rural women sampled were further away from key services, had reduced access to transport, were less likely to be in employment outside the home and were more likely to be eligible for a medical card than their urban counterparts (Batt and Nic Gabhainn, 2002). This lack of counselling and support services in rural areas may act as a contributory factor to social exclusion. A study of women's lives in a community in South West Mayo, for example, described how service depletion in rural areas placed a severe strain on women in particular, as they have added responsibility of caring for others who are young, elderly or unwell (Byrne and Owens, 1996).

Irish research has also found that girls living in a rural environment experience greater psychological difficulties than girls from urban areas (Houlihan, Fitzgerald and O'Regan, 1994). Kelleher *et al.* (1998)

examined variations in suicide in the eight Health Boards of the Republic of Ireland over the years 1976 to 1995, and found that since the mid-nineteen-eighties, female rates have been somewhat higher in the southern half of the country. They suggested that this variation might reflect a difficulty with contacting services for psychological distress in rural areas. This could be either because of stigma or simple practical problems associated with transport. Recommendations included putting the development of appropriate services, especially in rural areas, at the top of the health care agenda.

Carers

Internationally the burden of caring for the ill and the elderly falls primarily on women (Bredin, 1994; Morrow and Chappell, 1999; Prior, 1999). This burden carries with it an increased risk of mental and emotional distress, as well as physical repercussions, financial strain and reduced social interaction (Neufeld *et al.*, 2002). In a study of 700 people in London, being a woman carer was found to be a significant predictor of mental illness (Livingston, Manela and Katona, 1996). The recent policy shift towards care in community, while positive and desirable from a therapeutic perspective, has the potential to put carers, and especially women as primary carers, at an increased risk of mental distress (Bredin, 1994; Rhodes and Goering, 1998). In order to counterbalance the added strain, a number of support systems need to be implemented such as increased financial contributions from government and the provision of counselling services as well as respite care (Morrow and Chappell, 1999; Audit Commission, 2000).

The situation is very similar in Ireland, as its societal model of care is still very gendered. A recent report of the Equality Authority on carers found that six out of every ten carers were women. However, women comprised two thirds of those carers who provided 43 hours or more a week, i.e. full-time carers (Cullen, Delaney and Duff, 2004). The prevalence of women carers was also highlighted in The Women's Health Council's report *Women – The Picture of Health* (Conlon, 1999), and in recent studies of carers both in the South Eastern (Lane *et al.*, 2000) and Western Health Boards (O'Neill and Evans, 1999). The mental health of Irish carers has also been found to be affected from their caring role. Thirty-eight per cent of carers were reported to experience a 'great deal' of stress in caring by Ruddle and O'Connor (cited in Cullen, Delaney and Duff, 2004). Whereas Blackwell *et al.*, (ibid) found that one third of carers in their study had a level of psychological distress that put them at risk of clinically diagnosable anxiety/depression and this was double the rate for the general population.

The high level of psychological distress experienced by carers in Ireland can be attributed to the current inadequate provision of care services, including mental health services (Keogh, Roche and Walsh, 1999; O'Keane *et al.*, 2003; Goodbody Economic Consultants, 2004; Irish College of Psychiatrists, 2004; Mental Health Commission, 2004a; National Disability Authority, 2004). As mentioned, this situation places a considerable and inappropriate burden on Irish carers in terms negative repercussions in both financial and health terms. Considering the shift towards community care advocated in Irish government policies (Department of Health, 1984; Department of Health and

Children, 2001b), the need for support services for carers will become even more urgent. In order to protect the physical and mental health of carers as well as to prevent their unfair economic discrimination, The Equality Authority recommended the provision of respite care as well as income maintenance, protection of employment and career prospects and the continuation of social insurance contributions and entitlements (Cullen, Delaney and Duff, 2004). Access to counselling services is also vital to their mental and emotional wellbeing.

Women who abuse alcohol or drugs

Although the numbers of women misusing drugs are generally lower than they tend to be for men (Prior, 1999; WHO, 2001a; Canterbury, 2002), they still constitute a significant socially excluded group. Research has found that women are more likely to experience greater physical health repercussions from drug and alcohol abuse than men, as well as higher rates of depression and anxiety, suicidal tendencies, isolation and general psychological distress (Mowbray *et al.*, 1998; Canterbury, 2002; Cormier, Dell and Poole, 2004). The same findings have also been reported in Irish research studies. The reverse is also true, with estimates for concurrent drug abuse and mental health problems ranging between 30 per cent (Mowbray *et al.*, 1998) and 66 per cent (Cormier, Dell and Poole, 2004). The higher level of mental distress might be caused by the condemnatory and stigmatising discourses surrounding women's substance abuse, based on the notion that women who abuse drugs and alcohol go against gendered societal expectations. Social stigma and fear of losing the right to care for their children are the biggest obstacles to women accessing treatment (Hedrich, 2000; Klee, Jackson and Lewis, 2002; Walter *et al.*, 2003).

Treatment for women who are drugs and alcohol abusers would thus be best provided in facilities that do not denigrate them, and that do not deny them their social roles. Were such facilities available, the percentage of women seeking treatment would most likely increase. The establishment of integrated services which address the many needs of women drug users, including health care and social services, as well as mental health care and drug abuse specialists, in a multidimensional and non-judgemental setting has been recommended (Kohen, 2000; Canterbury, 2002; Klee, Jackson and Lewis, 2002). Residential facilities for women and their children are also advocated, and the provision of childcare services is perceived as critical to women's ability to access these services both from a practical and emotional standpoint (Moran, 1999). Finally, the importance of the provision of women-only treatment settings also needs to be highlighted. Research has shown that up to 70 per cent of women who misuse drugs have experienced violence, and that female drug users are more likely than men to have been victims of sexual or physical abuse (Hedrich, 2000; Canterbury, 2002; Cormier, Dell and Poole, 2004). Hence, the ability to access a safe environment is necessary for recovery.

Currently the male-female percentage for drug abuse in Ireland is 73-27 (Moran *et al.*, 2001), which mirrors international statistics. A similar ratio was also found among those accessing drug treatment centres within the state (29.8% for females vs. 70.2% for males) (Department of Health and Children, 2003b). As illustrated in Table 1 (page 11), males predominated in the admission rates to psychiatric treatment in relation to substance abuse, with an "alcohol disorder" diagnosis being twice as common, and a drug dependence diagnosis being almost three times as common among men than women (Daly

and Walsh, 2003). In relation to service provision, despite the fact that lack of childcare facilities has been found to be a major barrier for Irish women who wish to attend drug treatment (Farrell, 2001), only nine of the 45 drug treatment centres in Dublin provided crèche facilities in 1999 (Moran, 1999). As a high rate of social deprivation has been consistently found among treated drug users (O'Brien, 2001), there is a clear need for strategies to tackle poverty, provide better housing as well as access to educational opportunities, and supportive environments for parents and employment prospects, as outlined in the National Drugs Strategy (Department of Tourism Sport and Recreation, 2001). Within this context, particular increased attention should be paid to the specific treatment needs of women who abuse drugs and alcohol.

Homeless women

Homelessness functions to exacerbate every stress and adverse psychological outcome that has been documented for women in general, including poverty, violence, both physical and sexual, exploitation and abuse, disenfranchisement, inequality and substance abuse (Astbury and Cabral, 2000). The role of physical and sexual abuse among the causes of homelessness for women, as well as its negative repercussions cannot be underestimated. Astbury and Cabral argue that: "for women homelessness often represents both an escape and a trap, an escape from one hostile environment into another" (2000: 57). Irish research found that homeless women face increased risks to their health than do both the general population and their male counterparts. One hundred homeless women participated in a recent research study carried out on behalf of the Royal College of Surgeons of Ireland and the Children's Research Centre in Trinity College Dublin. The study found 'very high levels of physical and psychological conditions' in the sample population with 73 per cent experiencing some form of mental health problem. Depression was the most common complaint with 70 per cent of all respondents reporting depressive illness, almost half of which was untreated (Smith, McGee and Shannon, 2001). Drug use was common, with two thirds of the women having used illicit drugs in their lifetime. Moreover almost half were categorised as being or having been addicted to heroin. A history of serious physical and/or sexual abuse was also prevalent in the sample, and in the majority of cases the first instance of violence had occurred prior to their becoming homeless. In fact, violence was one of the two most commonly reported reasons for entry into homelessness, alongside inability to find affordable housing (Smith, McGee and Shannon, 2001). The link between violence and/or sexual abuse and homelessness in Ireland has also been documented by National Women's Council of Ireland (2000), and Carlson (1990).

In 2002, 151 patients with no fixed above were admitted to psychiatric hospitals or units, with only a minority of these being women (16%) (Daly and Walsh, 2003). Services for homeless persons with mental illness nationally have been found to be deficient (Mental Health Commission, 2004b; National Disability Authority, 2004). Smith *et al.* (2001) highlight the need for specialised counsellors, with specific skills in the area of abuse and drug addiction, in order to meet the psychological needs of homeless women. However, increased investment in affordable housing and greater commitment to tackling the problem of violence against women would also greatly reduce the number of homeless

women and thus their risk of experiencing mental health difficulties. Finally, it is important to point out that mental illness can be a cause as much as a consequence of homelessness in Ireland. In fact, patients leaving mental health institutions have been found to be at risk for homelessness (Department of Environment and Local Government, 2002). Hence, the provision of appropriate housing options, which incorporate mental health rehabilitation schemes, is needed in order to prevent a vicious cycle of homelessness and mental illness taking place.

Women in Prostitution

A number of oppressive conditions increase the likelihood of women and girls being drawn into prostitution by pimps and traffickers, such as living in poverty, being homeless and being drug dependent, gender inequality, including lack of access to social, economic and political power, sex and racial discrimination as well as sexual, physical and psychological violence by male relatives, boyfriends, husbands, pimps and others (Ekberg, 2003). "Sexual violence and physical assault are the normative experiences for women in prostitution" (Farley, 2003: 252). In a study carried out in nine countries, 71 per cent of women in prostitution had experienced sexual assaults, and 62 per cent had been raped (Farley, 2003). Research in the UK has shown that half of the women surveyed who worked within outdoor settings and over a quarter of those working indoors reported some form of violence by clients in the last six months (Church *et al.*, 2001). Moreover, international studies also show that "Post-Traumatic Stress Disorder" (PTSD) is common among prostituted women (Macready, 1998; Farley, 2003), and the majority of them have experienced sexual and/or physical abuse prior to being drawn into prostitution (Farley, 2003).

The high level of exposure to violence, as well as the high rate of drug addiction among women in prostitution is likely to cause serious physical and psychological consequences. Hence, specialised services are needed in order to address both the physical and mental health care needs of prostituted women. In the nine country studies referred to above, 89 per cent of the women in prostitution wanted to leave prostitution, but did not have any other options (Farley, 2003). Hence, programmes that enable prostituted women to exit prostitution through educational and employment opportunities are of paramount importance. It is only after a safe physical environment has been established that therapy aimed at addressing the chemical dependence and "PTSD" symptoms of women in prostitution can be addressed (Farley, 2003). Finally, the legal framework around prostitution is also critical. While a detailed discussion is beyond the purpose of this paper, policies that do not criminalize women, such as those introduced in Sweden in 1999, would prove beneficial to the well being of women in prostitution and reduce the level of violence that they experience. However, nothing would be more beneficial than the implementation of social policies that give women choices and prevent them from seeing prostitution as their only solution.

The SAVI Report (McGee *et al.*, 2002) in collaboration with the Ruhama Project in Dublin attempted to provide an estimate of the prevalence of sexual violence among women in prostitution. High prevalence of physical and/or sexual violence was reported both prior to entrance into prostitution

and following it (McGee *et al.*, 2002). Moreover child abuse or incest was the contributory factor most commonly identified by the Ruhama outreach workers, with financial difficulties a close second. Drug addiction was also mentioned often. Despite the high frequency of sexual assaults and rapes while working, most women in prostitution are very reluctant to access medical services, as they are afraid to be further victimised, and are ashamed of their involvement in prostitution. They also rarely avail of rape crisis counselling, as they question its effectiveness while the circumstances in their lives remain unchanged. Recommendations made in the report included increasing the public understanding of the situation of women in prostitution and the establishment of prevention programmes, as well as significant reforms in legal and social policies. Specific programmes aimed at enabling women to exit prostitution also need to be set up, so that real alternatives are available to women who find themselves working in prostitution.

Women in Prison

While women generally make up only a small percentage of the prison population, their numbers are on the increase (Henderson, Schaeffer and Brown, 1998; Veysey, 1998). The vast majority of women are incarcerated for non-violent crimes. In an American study only 13 per cent of women were arrested for violent crimes (Veysey, 1998). Approximately the same rate has been found in Ireland, where only 10 to 13 per cent of women commit serious offences (Bacik, 2004). Because of the predominance of the male population, women prisoners' needs have been consistently neglected (Pate, 2000; Pollack, 2002). Even when they are addressed, services tend to be based on models designed for the male population and are not appropriate (Veysey, 1998). Women in prison have been found to experience greater stress within the prison environment (Lindquist and Lindquist quoted in Mooney *et al.*, 2002). It may also be true that incarcerated women might have been exposed to higher levels of psychosocial adversity prior to incarceration.


Female prisoners have been found to have a higher level of psychiatric problems than their male counterparts (Veysey, 1998; Prior, 1999; Department of Health, 2002). This is also true in the Irish setting (Mooney *et al.*, 2002). Major mental illnesses are not more common within a prison setting than outside, but many prisoners have personality and behavioural problems, substance dependence and "neurotic disorders" (Prior, 1999). In a prevalence study carried out in an American large urban jail, Teplin found that 18.5 per cent of females had a diagnosable serious mental illness (the rate for their male counterparts was 8.9%), and 13.7 per cent of female admissions were diagnosed with a current episode of major depression (against 3.4% of males). In addition, 22.3 per cent of women in jail were diagnosed with "PTSD" (quoted in Veysey, 1998). The majority of women in prison have experienced child abuse and violence in their adult relationships (Veysey, 1998; Pollack, 2002). In a Canadian study, 82 per cent of all women prisoners had experienced serious histories of physical and/or sexual abuse (Pate, 2000). In addition a high number of incarcerated women have substance abuse problems and require specialised addiction counselling (Veysey, 1998; Pollack, 2002). Hence, specialised services for criminalized women with serious mental health difficulties, with specific attention to their experiences of abuse and addiction, need to be delivered within a 'safe'

environment in which a woman can explore past experiences and try to reconstruct a sense of identity (Pollack, 2002). Moreover, a history of social deprivation is common among women in prison and most of them would come from lower socio-economic groups. Hence, any treatment should not be based purely on a medical model and pathologies the individual, on the contrary, it should address the full context of women's lives and development. Consideration for their roles as primary caregivers as well as their low levels of education and limited employment opportunities also need to be addressed. Programmes should, therefore, be delivered in the areas of education, parenting, and vocational development (Pollack, 2002).

Even more beneficial would be a policy shift towards community alternatives to custodial sentences (Department of Health, 2002). A systematic review of literature on psychiatric services for incarcerated women recommended that a therapeutic community facility for women should be developed within the prison system (Lart *et al.*, 1999). This type of provision would enable incarcerated women to address their mental health needs, while reducing their social isolation²⁶. Moreover, as their mental health problems are unlikely to disappear upon release, follow up programmes also need to be developed (Morrow and Chappell, 1999; Pollack, 2002). Finally, as release from prison has been found to put women at risk of homelessness, transitional housing facilities need to be provided, alongside educational and employment training schemes, to ensure that the circumstances that brought them to prison in the first instance are not replicated.

On any given day there are between 100 and 110 women in prison in Ireland, compared to 3,000 men, but following an international trend they are one of the fastest growing sectors of the Irish prison population (Quinlan, 2003). The link between social deprivation and the female prison population is also very strong in Ireland (Bacik *et al.*, 1998). Women are usually incarcerated for committing 'poverty crimes', with theft being the most common offence. The Irish female prison population is also one of the youngest in Europe, with almost 50 per cent of women being 25 years of age or younger (Quinlan, 2003). The Governor of the Dochas Centre for Women claimed that Irish female prisoners have many more problems than their male counterparts (Irish Prison Inspectorate, 2003), in line with international findings. A study carried out in 1996 on Irish female prisoners (Carmody and McEvoy, 1996) showed that 71 per cent of their sample came from the inner city in Dublin and half of the participants had been treated for mental illness, with half of these having been admitted to a psychiatric hospital in their lifetime. A more recent study found that female prisoners had higher levels of mental health problems than their male counterparts (Mooney *et al.*, 2002). More incarcerated women than men in the sample had taken drugs at some stage in their lives (83% vs. 72%), and smoked or injected heroin (68% vs. 38% and 58% vs. 25% respectively). Female prisoners were also more likely to have experienced verbal, physical and sexual abuse, and to be on prescribed medication. Moreover, high levels of stress and poor quality of life seemed to predate their drug abuse and incarceration. Hence, the authors of the study called for more gender-specific knowledge to inform programmes and policy decisions (Mooney *et al.*, 2002).

26 The recent proposal by the Minister for Justice, Equality and Law Reform to move the women's prison to a location outside of the urban setting is particularly worrying in relation to women's social isolation, as any move outside of the transport system of the Dublin conurbation is likely to make visiting more difficult and reduce their contact with families, especially their children, and friends.



Despite the building of a new facility in 1999, the Dochas Centre for Women, mental health services for women prisoners are extremely poor. There have been no psychological services provided for the prisoners for the past two and a half years. Psychiatrists from the Central Mental Hospital provide a service two afternoons per weeks (Irish Prison Inspectorate, 2003). Of the seven beds reserved for women in the Central Mental Hospital, three are set aside for women prisoners, hence waiting times are exceedingly long. Counselling sessions are provided by the Probation and Welfare Officers, who might not have the relevant skills to tackle the difficult issues presenting to them. The services of Alcoholic Anonymous and Narcotics Anonymous are used within the centre, however, their input is not sufficient and dedicated drug counselling services should be available. Similarly, provision of rape crisis counselling can be procured from an outside provider one afternoon per week, but this set-up is unlikely to be satisfactory considering the high prevalence of a history of abuse among women prisoners. The lack of dedicated in-prison services for physical and sexual violence as well as drug abuse is extremely worrying and should be addressed as a matter of urgency. Finally, while educational programmes are provided, they have been found to have a less academic emphasis than those offered to men in Mountjoy Prison and follow a more traditional educational philosophy.

In 2003, the Inspector of Prisons and Places of Detention after his annual inspection claimed that many women prisoners have mental and emotional problems and, in many cases, "the Dochas Centre is no place for them" (Irish Prison Inspectorate, 2003: 85). The National Economic and Social Forum has strongly encouraged the adoption of non-custodial sentences (2002), and these would be extremely beneficial to women, who are rarely jailed for committing violent crimes. The provision of places in community mental homes for women prisoners experiencing mental health problems would be the best approach for their recovery. However, Ireland is one of the few countries in Europe that does not have prisoners in community mental homes (Bresnihan quoted in Martyn, 2002). This situation needs to be remedied urgently. The provision of housing after discharge is also of paramount importance for women, as up to a third of them become homeless upon release (Bacik, 2004). The government has cited opposition by local communities as the main reason for the lack of transitional housing (Department of Environment and Local Government, 2002); however, more needs to be done in order to improve the welfare of released women and prevent recidivism. PACE, an NGO working on behalf of women ex prisoners, is currently developing a resettlement project in Dublin for homeless female ex offenders, with accommodation for up to 18 women and a number of children. However, these numbers are still too low to address the problem and no such facilities are available anywhere outside of Dublin, preventing the re-unification of many women with their families.

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