Consortium for the Regional Support for Women in Disadvantaged and Rural Areas

Response to: Draft Mental Health Strategy 2021-2031

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Prepared by: Siobhán Harding
Women's Support Network
Email: policy@wsn.org.uk

Foyle Women's Information Network

Women's Regional Consortium: Working to Support Women in Rural Communities and Disadvantaged Urban Areas

1. Introduction

1.1 This response has been undertaken collaboratively by the members of the Consortium for the Regional Support for Women in Disadvantaged and Rural Areas (hereafter, either the Women's Regional Consortium or simply the Consortium), which is funded by the Department for Communities and the Department of Agriculture, Environment and Rural Affairs.

1.2 The Women's Regional Consortium consists of seven established women's sector organisations that are committed to working in partnership with each other, government, statutory organisations and women's organisations, centres and groups in disadvantaged and rural areas, to ensure that organisations working for women are given the best possible support in the work they do in tackling disadvantage and social exclusion.[1] The seven groups are as follows:

- ♀ Training for Women Network (TWN) – Project lead
- ♀ Women's Resource and Development Agency (WRDA)
- ♀ Women's Support Network (WSN)
- ♀ Northern Ireland's Rural Women's Network (NIRWN)
- ♀ Women's TEC
- ♀ Women's Centre Derry
- ♀ Foyle Women's Information Network (FWIN)

[1] Sections 1.2-1.3 represent the official description of the Consortium's work, as agreed and authored by its seven partner organisation

1.3 The Consortium is the established link and strategic partner between government and statutory agencies and women in disadvantaged and rural areas, including all groups, centres and organisations delivering essential frontline services, advice and support. The Consortium ensures that there is a continuous two-way flow of information between government and the sector. It also ensures that organisations/centres and groups are made aware of consultations, government planning and policy implementation. In turn, the Consortium ascertains the views, needs and aspirations of women in disadvantaged and rural areas and takes these views forward to influence policy development and future government planning, which ultimately results in the empowerment of local women in disadvantaged and rurally isolated communities.

1.4 The Women's Regional Consortium appreciates the opportunity to respond to the Department of Health's Draft Mental Health Strategy 2021-2031. This is a very important issue for all the people of Northern Ireland who are disproportionately impacted by mental health issues. It is also important in the context of Covid19 which is having greater impacts for women in many aspects of their lives but also in relation to their mental health.

1.5 Throughout this response the Consortium has sought to ensure the voices of women are clearly represented. We believe that it is essential for policy makers and Government to listen to the voices of the people who live here and for whom issues such as mental health have such importance. We have included throughout this response some of what local women have said in relation to their lived experience of mental health issues.

2.0 General Comments

The Women's Regional Consortium appreciates the opportunity to respond to the Department of Health's Draft Mental Health Strategy 2021-2031. We wish to make some general comments before answering the specific questions asked in the consultation document.

2.1 The Consultation Process

The consultation on the Draft Mental Health Strategy is very important for everyone who lives in Northern Ireland given the prevalence of mental health issues here and the severe impact that mental health problems can have on the lives of those affected and their families and friends. It is vital therefore to have a genuine consultation process and that engagement with this process is as wide as possible so that the resulting Mental Health Strategy can effectively meet the needs of the people who live here.

The Covid19 pandemic has had a huge impact on all our lives and on our ability to work and communicate with each other. For the community and voluntary sector the impacts of lockdown have meant that the ability to carry out normal ways of working have been severely curtailed. This has been particularly challenging for carrying out research work and in trying to effectively gather the views of people in relation to consultation exercises.

This consultation came at a time when the women's sector and indeed the wider voluntary and community sector has come under significant pressure with the sheer volume of consultations ongoing. Many of these consultations are also significant in terms of their importance and many have particular implications for the women's sector so have required an investment of time and resources to produce detailed responses.

We wish to acknowledge that the Department of Health allowed for a 12-week consultation period which is positive given that a number of other government consultations had significantly shorter consultation periods. However, we would

suggest that given the nature and importance of this Consultation and a range of external factors such as Covid19 restrictions on carrying out research and an already busy consultation environment that the period could perhaps have been longer to enable for more genuine and meaningful consultation.

We would refer the Department of Health to the guidance on consulting with women produced by Women's Regional Consortium members WRDA.[2] This guidance contains five top tips based on the many years of experience that women's groups have in promoting women's participation in public policy making. These include the need to work together with the women's community and voluntary sector, making time for accessible face to face engagement, keeping language accessible and relevant, listening to the stories from women and making women visible in the product as well as the process.

We also wish to acknowledge that the Department of Health organised a number of virtual consultation events during the consultation period along with a number of small, themed consultation meetings to discuss specific actions with the Strategy Project Team. We very much welcome this outreach and the ability to ask questions and make representations to the Strategy Project Team.

2.2 Rural Needs

In June 2017 the Rural Needs Act (Northern Ireland) 2016 was introduced and placed a statutory duty on public authorities to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services. The Act was introduced to ensure that consideration of the needs of people in rural areas becomes more firmly embedded within public authorities in Northern Ireland.

We are pleased that the Department of Health has included a Rural Impact Assessment Screening as part of this consultation. We believe that this is very

[2] Women at the Heart of Public Consultation, A guide for Public Authorities and Women's Organisations, WRDA, November 2017
https://wrda.net/wpcontent/uploads/2018/10/WRDA_WomenAtTheHeartOfPublicConsultation.pdf

important given the fact that Northern Ireland has a significant rural population with 36% of the population living in rural areas.[3] Those who live in rural areas often have less access to health services including mental health services than those in urban areas. Rural dwellers often have specific needs and experiences and it is vitally important that their needs are addressed given the importance of rural living in Northern Ireland. This must be a consideration for this Strategy particularly in relation to the reconfiguration of services.

2.2.1 Rural Access to Health Services

NIRWN's 2018 research[4] uncovered that many rural women felt that they were "*becoming more isolated, with many of our support agencies being located in urban settings."* Health appointments were consistently raised as an issue, both GP and hospital appointments. These are an extra burden to rural women as they are very often caring for both elderly relatives and young children and as such are tasked with organising the transportation to appointments. Transport was also raised as an issue. Those in rural areas said they found it was necessary to have access to their own transport to attend hospital due to lack of public transport and not knowing how long they may be at the hospital making it impossible to plan their return journey.

Research[5] indicates that costs 'saved' by the NHS in centralising services are, in reality simply transferred to patients. Rural dwellers, particularly those without private transport, are likely to be most disadvantaged by these changes. A recent study of a remote rural community in Northern Ireland found that district nurses had been withdrawn, GP surgeries had become larger and less personalised and GP out of hours services were located at substantial distances.[6]

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[3] Mid-Year Population Estimates – Urban/Rural Change, NISRA https://www.daera-ni.gov.uk/publications/mid-year-estimates-population-change

[4] Rural Voices Report, NIRWN, 2018 https://www.nirwn.org/wp-content/uploads/2018/03/NIRWN-Rural-Voices-Research-Report-March-2018.pdf

[5] Trend towards centralisation of hospital services, and its effects on access to care for rural and remote communities in the UK, Rural and Remote Health, Iain J Mungall, April 2005

[6] Rural ageing in Northern Ireland: Quality of life amongst older people, Professor Deirdre Heenan, March 2010

Experience of GP services varied greatly depending on location and examining this in the regional context the NIRWN's observations[7] on this issue are that there is no equity across the region in how GP services are delivered. Appointment availability, booking systems, available clinics, etc very much depend wholly on the General Practice and their own systems and guidelines.

There was a consensus amongst NIRWN research participants that, centralisation of support services was impacting on their communities locally, not just in terms of access poverty but also on exacerbating social isolation. The removal of regular meeting points, e.g. the Post Office which provided both a reason to leave the house and often a structure and social occasion, e.g. on pension day.

2.2.2 Role of Community Spaces in Rural areas in Addressing Social Isolation and Mental Wellness

There was agreement amongst those surveyed that rural women needed a place to meet and a reason to meet up. The conversations around this primarily linked inextricably to the provision of education and training for women in rural areas and the lack thereof. In relation to addressing social isolation those NIRWN spoke with concurred that being able to provide any class locally, should it be: yoga, craft classes, information talks etc, created a mechanism to engage those who were socially isolated.

NIRWN's member groups operate within their local area and as such hold local knowledge such as, who has recently suffered a bereavement, who is experiencing a difficult time, who has overwhelming caring responsibilities and as such they quietly and discreetly attempt to engage these people in their activities and offer to bring them along. This however is only possible if they are in a position to deliver activities locally; without exception all were finding that "*It is increasingly difficult to find funding to support overheads like room rental to be able to run any activities."*

[7] Rural Voices Report, NIRWN, 2018 https://www.nirwn.org/wp-content/uploads/2018/03/NIRWN-Rural-Voices-Research-Report-March-2018.pdf

NIRWN members can clearly identify themselves the impact of social isolation on health and wellness and the positive effect community-based activities and education can have on addressing this. They did not believe that decision makers, particularly at government level understood the impact that small amounts of money invested in local rural groups could potentially save the health sector, which is currently in crisis.

2.2.3 Impacts of Loneliness and Isolation on Mental Health

Whilst the nature of rural isolation and its associated impacts would seem to vary, it is clear that there will be individuals who experience negative impacts such as mental health issues, the risk of suicide and potentially reduced life expectancy.[8] Given these potentially negative impacts, the existence and even apparent growing impact of many of the potential causal factors identified such as the increases in people living alone[9] may raise concerns going forward.

Social networks and local community support play a critical role in helping people either to avoid or to overcome their experience of disadvantage, by providing emotional or practical support such as help with shopping, transport and money. Research[10] has highlighted the increasing importance of lack of community support and social isolation leading to disadvantage, as rural social networks are breaking down. UK research indicates that the additional costs of providing social care for older people may be exacerbating this problem.[11]

[8] Rural isolation, poverty and rural community/farmer wellbeing – scoping paper, Northern Ireland Assembly scoping paper, Mark Allen, June 2014
http://www.niassembly.gov.uk/globalassets/documents/agriculture-and-rural-development/reviews/anti-poverty/rural-isolation-poverty-and-rural-community-farmer-wellbeing---scoping-paper.pdf
[9] https://www.communities-ni.gov.uk/publications/northern-ireland-housing-statistics-2019-20
[10] Rural Disadvantage Reviewing the Evidence, Commission for Rural Communities, September 2006
https://www.basw.co.uk/system/files/resources/basw_33716-5_0.pdf
[11] Social isolation experienced by older people in rural communities, Commission for Rural Communities, September 2012
http://cdn.basw.co.uk/upload/basw_111815-1.pdf

Scottish research[12] indicated that stigma related to mental health issues is also particularly problematic. Rural areas are known to have strong communities and whilst this can act as a protective factor for people with mental health issues it can also be a barrier to them seeking and accessing services due to the perceived stigma of their circumstances. It was noted that decision makers do not have the same level of information and evidence regarding rural areas and this makes is harder to come up with solutions. NIRWN argue that data to support a Mental Health Strategy in its development and delivery requires quality data that is both gender disaggregated and takes account of rural and urban experiences.

2.3 Funding of the Strategy

The consultation document states: *"The draft Strategy does not include indicative costings. A separate Mental Health Funding Plan will be published alongside the full Strategy, and will provide a spending plan for mental health for the full period of the strategy, 2021-2031."* It is clear that many of the actions outlined in this consultation will not be achievable without the necessary funding attached. While funding is not part of this draft Strategy it is absolutely vital to its success. The consultation document goes on to say that: *"The investment required is in addition to existing expenditure in mental health services, and is dependent on new funding becoming available."*

We are concerned that many of the actions contained within this draft Strategy are dependent on new funding which is not yet available. We wish to reiterate that the success of this Strategy is highly dependent on having the necessary funds to carry out many of the actions contained within it.

"Only 6% of the health budget is spent on mental health. Yet we have more mental health issues here and despite this there is less spent on it and that can't be right."

[12] Mental Wellbeing, Social Isolation and Loneliness in Rural Scotland, Voluntary Health Scotland , February 2019
https://vhscotland.org.uk/wp-content/uploads/2019/11/Key-Messages-Mental-Wellbeing-in-Rural-Scotland-1.pdf

"It's all down to money at the end of the day."

2.4 Mental Health Problems in Northern Ireland

The figures around mental health problems in Northern Ireland are stark as highlighted in the consultation document: *"Northern Ireland has the highest prevalence of mental health problems in the UK, with a 25% higher overall prevalence of mental health problems than England."* The legacy of the Troubles is recognised as having a significant impact on mental health in Northern Ireland: *"39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles."*

The figures for young people are equally concerning showing the likelihood of continuing high levels of mental health problems long into the future in Northern Ireland: *"anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK."* These statistics give considerable impetus for the need for a wide ranging Mental Health Strategy with the necessary funding attached to ensure that it can be effectively delivered in Northern Ireland.

Figures from the Department of Health[13] show that women are more likely than men to experience mental health problems. 20% of women scored a high GHQ12 score (indicating a possible psychiatric disorder) compared to 16% of men with those in the most deprived areas more likely to record a high score compared to those in the least deprived areas. The age groups most likely to report a high score were women aged 55 – 64 followed by men aged 16 – 24 and women aged 45 – 54. Research shows that women are more likely to suffer from depression than men[14] with 22% of men and 28% of men over 65 suffering from depression.[15]

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[13] Health Survey Northern Ireland 2018/19, Department of Health, January 2020
https://www.health-ni.gov.uk/publications/health-survey-northern-ireland-first-results-201819

[14] Mental Health in Northern Ireland, Northern Ireland Assembly Research and Information Service, January 2017
http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf

[15] Mental Health Strategy 2021 – 2031, Consultation Draft, Department of Health, December 2020
doh-mhs-draft-2021-2031.pdf (health-ni.gov.uk)

There are a number of factors affecting women's mental health. Women are more likely to live in poverty than men and women are more likely to be providing care either for their children or for other family members. Poverty and working in the home can mean that women are more likely to be isolated and social isolation is linked to mental health problems. In addition, women are also more likely to be exposed to gender-based violence than men which can have long-term impacts on their mental health. When women find it hard to talk about difficult issues or are not given the support they need to deal with mental health issues they can internalise these issues and this can lead to depression, eating disorders and self-harm.

"There needs to be better care for mental health issues. I had issues with my mental health and without being able to be referred by my work to places for support I wouldn't have got anywhere in the normal health sector. Mental health is a bigger problem for women, it comes at women from more directions than men."

LGBTQ+ communities in Northern Ireland experience mental health issues at disproportionately high levels due to widespread social stigma, abuse and institutionalised homophobia, biphobia and transphobia. This combined with chronic underfunding of mental health services and a lack of cultural competency within these services makes the situation for LGBTQ+ communities even worse. Transgender people in Northern Ireland are currently unable to access life changing gender-affirming healthcare due to a lack of funding and extremely long waiting lists.[16] Those who are unable to access it in a timely and appropriate manner are disproportionately likely to experience severe mental health problems.

Black and Minority Ethnic (BAME) communities are generally considered to be at increased risk of poor mental health. Some of the challenges they face in accessing mental health services include language barriers, discrimination, difficulty with GP registration and other aspects of accessing care and the stigma associated with accessing mental health services.[17]

[16] Transgender Healthcare Is at Breaking Point In This Corner of Europe (vice.com)
[17] 'Walking this thin line' Black and Minority Ethnic (BME) Experiences of Mental Health & Wellbeing in N. Ireland, Institute for Conflict Research, December 2015

Given the prevalence of mental health issues in Northern Ireland we have concerns about the level of funding which is currently available to tackle these issues and the waiting lists that currently exist. We point to the concerns raised by PPR in terms of disparities in access to GP provided counselling services depending on where people live (see Section 2.11.1), the demand for counselling services provided by Women's Centres (see Section 2.10) and the long waiting lists for in-patient beds for those with poor mental health. Figures provided by the Northern Ireland Assembly[18] show that in January 2021 there were 514 inpatient beds available for people with poor mental health. The number of a people on a waiting list for these services is not readily available but information on the number of people who are on a waiting list for adult mental health services shows a total of 4,596 people waiting pointing to the pressure on these services.

"Mental Health issues are not new. It has been rising like a volcano for the last 20-30 years."

"The thing about mental health is that it is never something that is cured overnight. Once you admit it that's the first thing that helps. The more people who talk about mental health issues and tell these things the better."

"Mental Health affects everyone in some shape or form."

"I have suffered from mental health issues for 28 years. At the start I was given counselling straight away and also put on medication which took me some time weaning off it. They are so hard to come off. Then I had a good patch and didn't need counselling or medication. However, trauma is always there and if something else happens it can bring it all back. I had to seek help again and they put me into the hub and I had to sit and wait until they contacted me. Then you have to tell them on the phone how you are feeling. Then you have to wait another while until you get seen. It is a very long wait if you need help, it is too long. If I had wanted to kill myself I'd be dead in the wait."

'Waking this thin line Report' Black and Minoirty Ethnic (BME) Experiences of Mental Health Wellbeing in N.Ireland (conflictresearch.org.uk)

[18] http://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=321766

"There are a lot of issues for people with disabilities – people who can't express their needs. If they don't have family fighting for them they can't get access to services and support."

2.4.1. Stigma in relation to mental health

There is still considerable stigma in relation to mental health issues and this has implications for disclosure and seeking help. It is important to recognise how detrimental the stigma around these issues is and how it can keep mental health issues hidden and force people to suffer unnecessarily. The stigma around mental health has particular issues for women. Women are often fearful of reporting mental health issues for fear that they will be judged and viewed as 'mad'. Women reported fear of reporting mental health issues due to fear of social services involvement and being viewed as unfit to look after their children.

In addressing the issue of stigma women felt that it was important that these issues are talked about openly and that people should be encouraged to talk openly about mental health. It should be treated the same as physical health yet many people do not talk about it the way they would about a physical condition.

"I felt like I had failed at my life and couldn't work out why. If you are a diabetic you take an injection every day and that's OK. I take medication every day for anxiety and I'm not going to stop taking it because I don't want to admit to other people about it or care what others think."

"So much is unknown in relation to mental health that people are afraid of it, people are afraid of the label being attached to them. People are afraid of being judged – how can she work full time if she has these things wrong with her?"

"I couldn't tell my family my son was depressed. Felt like I was alone and that everyone else seemed happy. But in hindsight a lot of my family were going through it too and no one was talking about it."

"There is big stigma around mental health. People think you are not wise. They think they don't want to be around you but you are still the same person. You can be tainted by association – my mother had mental health issues and people call me mad."

"When I told my GP about my mental health issues he said are you not worried that this will go on your record? I had mental health issues, this was the least of my worries, I just wanted help."

2.5 Poverty and mental health

Action to address poor mental health and promote positive mental health cannot be achieved without addressing the broader social and economic determinants of ill health. It is important to recognise that poor mental health is strongly linked with these social and economic circumstances such as poverty, unemployment, low paid and low quality work.

Research shows that poverty increases the risk of mental health problems and that poverty can be both a cause of mental health problems as well as a result of them. Statistics from the Mental Health Foundation show that those living in lower socio-economic groups are more likely to experience chronic ill-health and those in the most deprived areas of Northern Ireland are twice as likely to show signs of a mental health problem (30%) than those in the least deprived areas (15%).[19] Austerity and public cuts have also hit Northern Ireland hardest as it relies more heavily on public spending for its output compared to the UK.

Sir Michael Marmot who carried out a government review on health inequality has said that increasing out-of-work benefits and support for low-paid workers as the country emerges from the pandemic could have a big impact in curbing a mental health crisis and even save lives. He said in an interview that Government Ministers should not "*fiddle around the edges*" and instead should drastically reform the "*uncaring*" system in place. He said: *"I have seen evidence that for some people in receipt of Universal Credit, there are mental health consequences. It is a brutalising system. Everyone should have at least the minimum income necessary for a healthy life."* He went on to say that: *"And in work, they should be paid a living wage. If they can't work, for whatever reason, then the welfare system should be sufficiently*

[19] Mental Health in Northern Ireland: Fundamental Facts 2016, Mental Health Foundation, https://www.mentalhealth.org.uk/sites/default/files/FF16%20Northern%20ireland.pdf

generous for their health not to be damaged by that experience. We know what needs to be done. Let's do it."[20]

Northern Ireland's Interim Mental Health Champion, Professor Siobhán O'Neill has called for a "recovery plan" across society to deal with the impact of the pandemic on mental health.[21] Professor O'Neill has stressed that the budget for mental health services in Northern Ireland needs to be increased given the greater demand which is likely to be placed on mental health services in the aftermath of the pandemic. She also addressed the groups who are particularly vulnerable to mental health challenges as a result of the pandemic including young people, women and people with children at home as well as those with pre-existing medical conditions and those on low incomes. The plan includes interventions for those in socially deprived areas with Professor O'Neill stressing the benefits of targeting specific low-income locations and the benefit this has on mental health.

Women's socio-economic status and concentration in lower paid, part-time and insecure work as well as the fact that women are more likely to claim social security benefits keeps their incomes lower over their lifetimes and makes them more vulnerable to poverty and financial hardship.

The region with the highest proportion of jobs paid below the Living Wage in April 2020 was Northern Ireland (25.3%). Women are significantly more affected by low pay than men with more women earning less than the Living Wage in the UK (23.8% compared to 16.6%). Part-time jobs (35.9% or 2.8 million jobs) were much more likely to be paid below the Living Wage in April 2020 than full-time jobs (14%).[22] Women are significantly more likely to work part-time than men with 79% of part-time employees being women.

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[20] https://www.theguardian.com/politics/2021/mar/21/raise-benefits-to-curb-uk-crisis-in-mental-health-expert-urges

[21] https://www.belfasttelegraph.co.uk/news/northern-ireland/nis-mental-health-champion-calls-for-recovery-plan-in-aftermath-of-pandemic-40212739.html

[22] Employee jobs paid below the Living Wage: 2020, Living Wage Foundation, November 2020 https://www.livingwage.org.uk/employee-jobs-paid-below-living-wage-2020

Women are also more likely to be employed on a zero-hours contract than men with 3.6% of women employed on these contracts compared to 2.8% of men across the UK.[23] Single parents are twice as likely to have a zero-hours contract as other family types.[24]

Women make up half of the working age population however nearly a third of working age women are 'economically inactive'. The Northern Ireland economic inactivity rate has increased to 27% and it is consistently above the UK average (now at 20.7%). The female economic inactivity rate is 30.9% compared to 23% for men.[25] In looking at the detail of economic inactivity it shows that more than a third of women who were unavailable for work gave the reason for inactivity as family/home commitments (61,000 or 34%) and this was the least likely reason for male inactivity (at 8,000 or 6%).[26]

Poverty is already an issue which impacts of on the lives of many women in Northern Ireland and is harmful not only to the women themselves but to their children, families and wider communities. Women are generally more likely than men to live in poverty across their lifetimes – of all those living in poverty in Northern Ireland 36% are female and 31% are male.[27] Lone parents (in Northern Ireland 91% of lone parents are women[28]) are even more vulnerable to poverty. In Northern Ireland 37% of single parents are living in poverty.[29] Women often bear the brunt of poverty in the home managing household budgets to shield their children from its worst effects. This

[23] People in employment on zero hours contracts, Office for National Statistics, August 2020
https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/emp17peopleinemploymentonzerohourscontracts
[24] Caring without sharing, Gingerbread, November 2020
https://www.gingerbread.org.uk/wp-content/uploads/2020/11/Gingerbread-Caringwithoutsharing-v3.pdf
[25] Northern Ireland Labour Market Report, NISRA, January 2021
https://www.nisra.gov.uk/system/files/statistics/labour-market-report-january-2021.pdf
[26] Women in Northern Ireland 2020, NISRA, June 2020
https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Women%20in%20NI%202020_0.pdf
[27] Households Below Average Income: Northern Ireland 2018/19, DfC & NISRA
https://www.communities-ni.gov.uk/system/files/publications/communities/hbai-2018-19.pdf
[28] Census 2011 – Key Statistics for Gender, Research and Information Service Research Paper, Ronan Savage and Dr Raymond Russell, Northern Ireland Assembly, 5 September 2014
http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/general/3415.pdf
[29] Households Below Average Income: Northern Ireland 2018/19, DfC & NISRA
https://www.communities-ni.gov.uk/system/files/publications/communities/hbai-2018-19.pdf

means that women end up acting as the 'shock absorbers' of poverty going without food, clothes or warmth in order to meet the needs of other family members when money is tight.[30]

"As long as my two kids are fed and watered I don't care if I eat."
(Quote taken from Women's Regional Consortium Research on the Impact of Austerity/Welfare Reform on Women, March 2019)

As previously stated, women are more likely to be in receipt of social security benefits, more likely to be in low-paid, part-time and insecure work and also more likely to be providing care which limits their ability to carry out paid work. This contributes to keeping women's incomes generally lower over their lifetimes and therefore puts them at greater risk of poverty. These existing gender inequalities are also likely to be further worsened due to the Covid19 pandemic (see Section 2.8).

"At the end of the day women and mothers are left with the burden of these issues (referring to low-incomes and poverty). They worry about these things."
(Quote taken from Women's Regional Consortium Research on the Impact of Austerity/Welfare Reform on Women, March 2019)

A decade of austerity and welfare reform policies have disproportionately impacted on women. Research by the House of Commons Library shows that 86% of the savings to the Treasury through tax and benefit changes since 2010 will have come from women. It shows that, by 2020, men will have borne just 14% of the total burden of welfare cuts, compared with 86% for women.[31] These welfare reform and austerity measures have tended to limit the ability of the system to protect against poverty.[32]

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[30] A Female Face, Fabian Society Blog by Mary-Ann Stephenson, Women's Budget Group, February 2019
https://fabians.org.uk/a-female-face/

[31] Estimating the gender impact of tax and benefit changes, Richard Cracknell, Richard Keen, Commons Briefing Papers SN06758, December 2017
http://researchbriefings.files.parliament.uk/documents/SN06758/SN06758.pdf

[32] Protecting dignity, fighting poverty and promoting social inclusion in devolved social security, Dr Mark Simpson, Ulster University, June 2018
http://www.niassembly.gov.uk/globalassets/documents/raise/knowledge_exchange/briefing_papers/series 7/simpson060618.pdf

An analysis of the impact of the reforms by the Northern Ireland Human Rights Commission (NIHRC)[33] showed that across most income levels the overall cash impact of the reforms is more negative for women than for men. This is particularly the case for lone parents (who are mostly women) who lose £2,250 on average, equivalent to almost 10% of their net income.

"I don't know how anyone does it as a single parent. The cost of milk, nappies. There is a ripple effect on children."

(Quote taken from Women's Regional Consortium Research on the Impact of Austerity/Welfare Reform on Women, March 2019)

Research by the Women's Regional Consortium on the impact of austerity[34] and on the impact of Universal Credit[35] on women shows the extent to which changes to the social security system have worsened women's ability to provide for their children and families and made them more vulnerable to financial hardship and poverty. Gendered policies such as the two-child limit and Benefit Cap as well as the introduction of Universal Credit which has been described as discriminatory by design have caused many women to struggle to afford the basics and to feed and provide for their children and families.

"It's degrading – how can I provide for my family? Kids ask can we get this, can we get that and I have to say no all the time."

(Quote taken from Women's Regional Consortium Research on the Impact of Austerity/Welfare Reform on Women, March 2019)

Concerns about austerity measures have been raised internationally by the CEDAW Committee. Following its recent examination of the UK, the CEDAW Committee raised concerns about the impact of austerity measures on women stating its concern about the *"disproportionately negative impact of austerity measures on women, who constitute the vast majority of single parents and are more likely to be*

[33] Cumulative impact assessment of tax and social security reforms in Northern Ireland, NIHRC, November 2019
https://www.nihrc.org/uploads/publications/Final_CIA_report_Oct_2019.pdf
[34] Impact of Ongoing Austerity: Women's Perspectives, Women's Regional Consortium, March 2019
http://www.womensregionalconsortiumni.org.uk/sites/default/files/Impact%20of%20Ongoing%20Austerity%20Women%27s%20Perspectives.pdf
[35] The Impact of Universal Credit on Women, Women's Regional Consortium, September 2020
http://www.womensregionalconsortiumni.org.uk/sites/default/files/The%20Impact%20of%20Universal%20Credit%20on%20WomenRevised.pdf

engaged in informal, temporary or precarious employment." [36] The Committee recommended that the UK government "*undertake a comprehensive assessment on the impact of austerity measures on the rights of women and adopt measures to mitigate and remedy the negative consequences without delay."* [37]

It is therefore clear that women have been more negatively impacted by a decade of welfare reform and austerity policies. This weakening of the social security safety net has meant that many women are struggling to afford basic essentials and to provide for their children and families. The causes untold stress and anxiety to these women limiting their life chances and wellbeing and impacting negatively on their mental health.

"The social security system does not allow people to live lives with dignity."

"The benefits system doesn't help people to go out and seek work. The jobs women do are often the lowest paid. If they leave benefits for low paid work they just end up getting further into the poverty trap."

The social security system has a vital role to play in easing the impact of poverty on people and families. As the Covid19 pandemic has shown, people need to be able to rely on the social security system when times get tough and they are hit by unexpected costs or lost earnings. However, the welfare reform and austerity measures introduced have tended to limit the ability of the system to protect against poverty.[38]

[36] Concluding Observations on the eighth periodic report of United Kingdom of Great Britain and Northern Ireland, CEDAW/C/GBR/CO/8, March 2019 (para 17) https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GBR/CO/8%20&Lang=En

[37] Ibid, para 18

[38] Protecting dignity, fighting poverty and promoting social inclusion in devolved social security, Dr Mark Simpson, Ulster University, June 2018 http://www.niassembly.gov.uk/globalassets/documents/raise/knowledge_exchange/briefing_papers/series 7/simpson060618.pdf

A recent case highlights the importance of the social security system in providing for those suffering from mental health issues and also how the social security system itself can exacerbate mental health issues which can lead to tragic consequences.

A single mother Phillipa Day aged only 27 took a fatal overdose after her benefit payments were cut. Phillipa was found collapsed in her home beside a letter rejecting her request for a home visit to assess her benefits in August 2019. She later died in hospital. Nottingham Coroner's Court heard that the way Phillipa's claim was dealt with was the "predominant factor" in her overdose.

Phillipa had been diagnosed with unstable personality disorder and had been receiving Disability Living Allowance as she had diabetes. The payments stopped after she made an application for Personal Independence Payment in January 2019 reducing her income from £228 a week to just £60. The inquest heard that this was due to a missing form which meant that her payments were not reinstated for months despite her eligibility. This led to her taking out short-term loans and getting into debt.

In June 2019 she contacted the DWP and said she was "starving" and "couldn't survive like this for much longer". She was then asked to attend a face-to-face assessment despite this being distressing for her. The Coroner said that Phillipa's mental health problems were "exacerbated" by the benefits process and that call handlers repeatedly failed to flag that the case required "additional support" due to her mental health problems. The DWP did not tell her Community Psychiatric Nurse that she had not returned the form before refusing her application which could have resolved the issue.

2.6 Universal Credit and Mental Health

Financial difficulties can cause or exacerbate mental health issues and strain relationships and support networks. Research has shown a connection between Universal Credit and mental health problems.

A study published in the Lancet medical journal[39] showed a link between Universal Credit and an increase in mental health problems among vulnerable benefit claimants. The analysis suggests that the introduction of Universal Credit has led to an increase in psychological distress of 6.6% among unemployed people on Universal Credit compared to the social security benefits which it replaced. "*In total, an estimated 63,674 unemployed Universal Credit claimants, or 95% of participants in the study, showed signs of worsening mental health – a third of whom (21,760) were suffering with medical depression*."[40] The study warned that this number is likely to continue to rise as the roll-out is finally completed.

A study by the Trussell Trust has revealed the detrimental impact the Universal Credit five-week wait is having on people's mental health. Many people reported experiencing high levels of anxiety, especially as they did not know how much they would receive and when. Some even reported feeling suicidal.[41]

Members of the Public Accounts Committee heard in July 2018 that claimants were facing "*considerable hardship and considerable deterioration in their mental health"* because of Universal Credit. Sophie Corlett, Director of External Relations for mental health charity Mind told Committee members that claimants "*struggle with the online application, they struggle with the conditionality that comes while you wait for your work capability assessment (WCA), they struggle with waiting for their first payment and if they are able to get an advance payment they struggle to pay that back."*[42]

[39] Effects on mental health of a UK welfare reform, Universal Credit: a longitudinal controlled study, Sophie Wickham, Lee Bentley, Tanith Rose, Margaret Whitehead, David Taylor-Robinson, Ben Barr, The Lancet, March 2020 https://www.thelancet.com/action/showPdf?pii=S2468-2667%2820%2930026-8

[40] Ibid

[41] #5WeeksTooLong, Why we need to end the wait for Universal Credit, The Trussell Trust, September 2019 https://www.trusselltrust.org/wp-content/uploads/sites/2/2019/09/PolicyReport_Final_ForWeb.pdf

[42] https://www.mind.org.uk/news-campaigns/campaigns/benefits/universal-credit/

A report by the Scottish Association for Mental Health (SAMH)[43] found that Universal Credit is causing hardship and emotional distress for people with mental health problems. The report detailed how good and fair employment can help a person's mental health and moves to simplify the social security system are welcomed. However, it showed that these aims have been undermined through the structure and delivery of Universal Credit and has instead added new barriers for people with mental health problems. SAMH warned that work coaches who make decisions over eligibility are not trained in mental health or disability, applications are digital by default which often acts to exclude those who need support and of the hardship caused by the five-week wait.

The Money and Mental Health Policy Institute found that nearly half of working age people receiving benefits have a mental health problem.[44] Mental health problems can make navigating the benefits system harder sometimes with serious consequences. Many people struggle to navigate the benefits system, including Universal Credit, because of common symptoms such as reduced concentration, increased impulsivity and memory problems. Problems affect all parts of the claiming process, from initial applications through providing evidence and attending assessments, to managing payments and challenging decisions. Claimant's mental health difficulties are being compounded by overly complicated and bureaucratic processes which are causing significant psychological distress for many people already struggling with their mental health.

Joseph Rowntree research on Universal Credit in Northern Ireland[45] showed that debt was a constant feature for many of the participants: *"A 'domino effect' was often*

[43] Universal Credit and Mental Health: Recommendations for Change, SAMH, March 2019 https://www.samh.org.uk/documents/ItWasAConfusionReport_ONLINE_VERSION.pdf
[44] The Benefits Assault Course, Money and Mental Health Policy Institute, March 2019 https://www.moneyandmentalhealth.org/wp-content/uploads/2019/03/MMH-The-Benefits-Assault-Course-UPDATED.pdf
[45] Universal Credit could be a lifeline in Northern Ireland, but it must be designed with people who use it, Ruth Patrick and Mark Simpson, with UC:Us, Joseph Rowntree Foundation, June 2020 Universal Credit could be a lifeline in Northern Ireland, but it must be designed with people who use it | JRF

experienced, debt led to more debt and aggravated mental health problems as people struggled to meet essential needs."

Research by the Women's Regional Consortium on the impact of Universal Credit on women in Northern Ireland showed that the five-week wait for Universal Credit was very negative. The personal impacts of the five-week wait were severe with 89% of the women reporting suffering stress/anxiety as a result of the wait and the worry about how they would provide for their families.[46]

"I felt degraded on Universal Credit, it affected my mental health and self-esteem. The system does not work and the most vulnerable will be going through hell with this system."

Giving people sanctions and small payments on Universal Credit keeps us in a low place and causes depression and anxiety because they cannot afford to live and feed and clothe their children. It's very sad."

"I was really stressed in December about Universal Credit because it was two weeks before Christmas and I was told I wasn't getting anything. I ended up going to see my GP over it."

(Quotes taken from Women's Regional Consortium Research on the Impact of Universal Credit on Women, September 2020)

"Even before Covid there were lots of people reliant on foodbanks because of Universal Credit, the 5-week wait, 2 child limit, etc. These things only push people into poverty. Universal Credit is not fair to people it just penalizes people. I feel there are not the right benefits in place."

2.7 Impact of Debt

Research by the Women's Regional Consortium on debt and women[47] focused on the different types of borrowing available to low income women with a focus on problem debt and high-cost lending. This research showed that 87% of the women

[46] The Impact of Universal Credit on Women, Women's Regional Consortium, September 2020 http://www.womensregionalconsortiumni.org.uk/sites/default/files/The%20Impact%20of%20Universal%20Credit%20on%20WomenRevised.pdf

[47] Making Ends Meet: Women's Perspectives on Access to Lending, Women's Regional Consortium, February 2020 http://www.womensregionalconsortiumni.org.uk/sites/default/files/Making%20Ends%20Meet%20-%20Women%27s%20Perspectives%20on%20Access%20to%20Lending.pdf

involved in the research had needed to borrow money in the last three years and most of it was for essential items and to make ends meet. Many had resorted to high-cost lending and difficulty meeting their debt repayments was a common problem.

Debt is closely related to financial exclusion and has been shown to be associated with issues such as family breakdown, lower labour market participation and health issues.[48] In their report on unmanageable debt[49] Citizens Advice highlighted that nearly three quarters of their debt clients said they felt anxious or stressed because of their debts. Unmanageable debt increases anxiety and stress, disrupts sleep and can have a negative influence on general wellbeing. Citizens Advice research also found that people with unmanageable debt are 24% more likely to experience poor mental health.[50]

Debt puts a huge strain on families including children. Research by The Children's Society[51] found that children in households who have debt with arrears are five times more likely to have low well-being than those with no difficulties with debt. This research found that there was an overwhelming sense of shame and embarrassment felt by both parents and children – parents felt ashamed of not being able to manage money effectively; children felt embarrassed by being unable to afford normal things like their peers, and being unable to socialise.[52]

[48] The Impact of Personal Indebtedness in United Kingdom Households, Especially on Children, House of Lords Library Note, LLN 2014/029, August 2014
https://researchbriefings.files.parliament.uk/documents/LLN-2014-029/LLN-2014-029.pdf
[49] A debt effect? How is unmanageable debt related to other problems in people's lives? Citizens Advice, July 2016
https://www.citizensadvice.org.uk/Global/CitizensAdvice/Debt%20and%20Money%20Publications/The%20Debt%20Effect.pdf
[50] Ibid
[51] The Damage of Debt, The impact of money worries on children's mental health and well-being, The Children's Society, September 2016
https://www.childrenssociety.org.uk/sites/default/files/the-damage-of-debt-2016.pdf
[52] Ibid

Locally NICVA research on expensive lending[53] also highlighted a common theme of the traumatic effect of indebtedness on the lives of the borrower and their family. Contributors cited issues around stress, their mental health and self-esteem and knock-on impacts on children.

Debt advice charity, Christians Against Poverty (CAP) has tragically reported that UK-wide 35% of their clients considered or even attempted suicide as a way out of debt.[54] In Northern Ireland CAP reports that three in five (58%) of the households they helped were affected by mental ill-health, which is approximately three times the national average of one in five of the Northern Irish population who suffer from a mental ill-health condition at any one time.[55] Social isolation is also a feature of debt causing people to withdraw because they cannot afford to socialise or feel ashamed of their situation. 85% of CAP clients in Northern Ireland report signs of being socially isolated or feeling lonely.[56]

The research by the Women's Regional Consortium found that living with debt caused great anxiety and stress impacting on women's personal wellbeing and relationships as well as limiting their opportunities and those of their children. There is a substantial body of evidence to suggest that debt can have serious negative consequences for borrowers especially on their mental health. It can damage relationships, limit children's opportunities and sometimes it can even drive borrowers to end their life. Tackling the issue of problem debt and the dangerous consequences of high-cost credit must therefore be a priority particularly for low-income households.

"You are always worrying about your debts, it's scary."

"The impact of debt is that it makes you very ill."

[53] Expensive Lending in Northern Ireland, Centre for Economic Empowerment, NICVA, May 2013 https://www.nicva.org/sites/default/files/d7content/attachments-resources/cee_expensive_lending_in_northern_ireland_2013.pdf
[54] Client report, Changing perceptions, Northern Ireland edition, Christians Against Poverty, April 2019 https://capuk.org/fileserver/downloads/general/Client-Report-2019-NI-WebDP.pdf
[55] Ibid
[56] Ibid

"It's the worry and anxiety of it – it puts a strain on family relationships."
"The only thing my partner and I argue about is money."
"I'm on my own so its constantly a worry making ends meet with the kids."

"If I have to be broke I'll never get a loan like that off anyone again. It's very stressful. If my father knew he'd be angry but I just feel like I just can't keep going to family to ask them for money all the time. I lost a good friend over not being able to buy her daughter birthday or Christmas presents because I couldn't afford it."

"There are lots of suicides in the area and other issues with drugs and addiction. People are struggling with losing their jobs and getting in too deep with money or loans."

"I am seriously anxious if I can't meet my repayments."

(Quotes taken from Women's Regional Consortium Research on Making Ends Meet: Women's Perspectives on Access to Lending, February 2020)

2.8 Impact of Covid19 on Women

The ongoing Covid19 pandemic has created unprecedented challenges across the world. The crisis affects men and women differently and in many cases deepens the inequalities that women already experience. The EU's annual report on gender equality, published in March 2021, found that the pandemic *"has exacerbated existing inequalities between women and men in almost all areas of life"*. The report claimed that it could *"take years, or even decades"* to overcome these setbacks.[57]

Women are more likely to bear the brunt of this crisis for a number of reasons:

- Women are more likely to be low paid and in insecure employment. Women were the majority of low paid earners (69%) the majority of those in part-time employment (74%), involuntary part-time employment (57%), temporary

57 https://ec.europa.eu/info/sites/info/files/aid_development_cooperation_fundamental_rights/annual_report_ge_2021_en.pdf

employment (54%), zero-hours contracts (54%) and part-time self-employment (59%).[58]

- Female employees were more likely than male employees to be working in jobs paying the National Minimum Wage. Low paid women were more likely than low paid men to remain stuck in low paid jobs;[59]
- Women are twice as likely to be key workers as men, 65% of key workers are female compared to 47% of the whole working population;[60]
- In Northern Ireland women make up 79% of health and social care staff.[61]
- Many of the workers in health and social care sectors are low paid. 98% of the 1 million high exposure key workers being paid less than 60% of median average wages are women.[62]
- Employed women were a third more likely than employed men to work in shutdown sectors over the first national lockdown with one in six (17%) of female employees in such sectors compared to one in seven (13%) of male employees[63] making them at particular risk of job loss.
- HMRC statistics show that across the UK more women than men were furloughed with 1.92 million females furloughed at 30 November 2020 compared with 1.79 million men.[64]

[58] Submission to the Women and Equalities Select Committee inquiry: Unequal impact? Coronavirus and the gendered economic impact, Women's Budget Group, June 2020
https://wbg.org.uk/wp-content/uploads/2020/06/WBG-Gender-economic-impact-submission.pdf
[59] Unequal impact? Coronavirus and the gendered economic impact, Women & Equalities Committee, UK Parliament, February 2021
https://publications.parliament.uk/pa/cm5801/cmselect/cmwomeq/385/38502.htm
[60] Risky business, Economic impacts of the coronavirus crisis on different groups of workers, Resolution Foundation Briefing, April 2020
https://www.resolutionfoundation.org/app/uploads/2019/10/Risky-business.pdf
[61] Who Runs Northern Ireland? A Summary of Statistics Relating to Gender and Power in 2020, Northern Ireland Assembly Briefing Paper, January 2020
http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2020/assembly_exec_review/0120.pdf
[62] Low-paid women in UK at 'high risk of coronavirus exposure', The Guardian, March 2020
https://www.theguardian.com/world/2020/mar/29/low-paid-women-in-uk-at-high-risk-of-coronavirus-exposure
[63] Sector shutdowns during the coronavirus crisis: which workers are most exposed? Institute for Fiscal Studies Briefing Note BN278, April 2020
https://www.ifs.org.uk/uploads/BN278-Sector-Shutdowns.pdf
[64] Coronavirus Job Retention Scheme statistics: January 2021, HMRC
https://www.gov.uk/government/statistics/coronavirus-job-retention-scheme-statistics-january-2021/coronavirus-job-retention-scheme-statistics-january-2021

- On average, women carried out 60% more unpaid work than men reducing the time available for paid work meaning that they earn less, own less and are more likely to be living in poverty.[65]
- Women are less likely to be eligible for Statutory Sick Pay (SSP) because they are overrepresented in low paid work and on zero hours contracts. Women's Budget Group calculations find that 15.5% of women and 10.6% of men do not earn enough to qualify for SSP.[66] This points to a disproportionate financial impact of self-isolation on women.

In July 2020 the Women's Policy Group Northern Ireland published a comprehensive Feminist Recovery Plan[67] highlighting many of these issues and calling on decision-makers across the UK to take action to ensure a gender-sensitive response in the transition from crisis response to recovery. This plan provided clear evidence for how to prioritise actions coming out of the pandemic. Despite this call there has been little progress in alleviating the impact of the pandemic on women.

A Women and Equalities Committee report[68] into the gendered economic impact of the Coronavirus crisis has highlighted how existing gendered inequalities in the economy have been ignored and sometimes exacerbated by the pandemic policy response. The Committee stated: *"We are concerned that the Government Equalities Office (GEO) did not anticipate how inequalities were likely to be exacerbated by the pandemic and ensure that it influenced the policy response, including in relation to employment, welfare, childcare and pregnancy and maternity. We have seen little evidence that the Government has conducted any robust or*

[65] Women shoulder the responsibility of 'unpaid work', Office for National Statistics, November 2016
https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/womenshouldertheresponsibilityofunpaidwork/2016-11-10
[66] Submission to the Women and Equalities Select Committee inquiry: Unequal impact? Coronavirus and the gendered economic impact, Women's Budget Group, June 2020
https://wbg.org.uk/wp-content/uploads/2020/06/WBG-Gender-economic-impact-submission.pdf
[67] Covid-19 Feminist Recovery Plan, Women's Policy Group NI, July 2020
https://wrda.net/wp-content/uploads/2020/07/WPG-NI-Feminist-Recovery-Plan-2020-.pdf
[68] Unequal impact? Coronavirus and the gendered economic impact, Women & Equalities Committee, UK Parliament, February 2021
https://publications.parliament.uk/pa/cm5801/cmselect/cmwomeq/385/38502.htm

meaningful analysis of the gendered impact of its economic policies during the Coronavirus crisis."

Following the publication of this report a coalition of organisations including the Trades Union Congress (TUC), Amnesty International, Save the Children and the Fawcett Society have signed a letter to the Equality and Human Rights Commission (EHRC) arguing that the government has failed in its duty to consider the impact of key policies on women and other groups protected under the Equality Act.[69] The letter states: *"This is a time of crisis for women. The coronavirus pandemic is having a significant and disproportionate impact on women's health, jobs and livelihoods. The policy decisions taken by government and other key public bodies in response to coronavirus are worsening the impact of the pandemic and deepening inequalities faced by women. The consequences of these decisions will affect women for years to come."*

It is clear that some groups are particularly affected by the pandemic. The low paid, young and female workers stand out as the groups putting their lives at risk by continuing to work in close proximity to others, and most likely to be experiencing direct financial pain from the economic shut down.[70]

It is imperative that as society emerges from the Covid19 pandemic and resulting recession that women must not pay the price as they did for the previous financial crash. Women have already suffered immensely due to a decade of austerity policies and this must not be allowed to happen again. There is a real need in Government recovery planning for targeted support to ensure that those who have been impacted the most by this pandemic are given the help they need to prevent and reduce poverty.

[69] https://www.theguardian.com/society/2021/feb/15/ehrc-urged-to-investigate-ministers-for-equality-failures-in-covid-response

[70] Risky business, Economic impacts of the coronavirus crisis on different groups of workers, Resolution Foundation Briefing, April 2020 https://www.resolutionfoundation.org/app/uploads/2019/10/Risky-business.pdf

"Women don't have equal rights and Covid has highlighted a lot of that. Women are struggling with homeworking, looking after children and working at the same time. Men's jobs are seen as more important."

"It's a real hard time for everyone especially women."

"Caring mostly falls to women, it's a big issue for women."

2.9 Covid19 and the impact on Mental Health

Research by the Office for National Statistics (ONS)[71] provides an insight into the mental health of adults during the coronavirus pandemic. It showed:

- Almost one in five adults (19.2%) were likely to be experiencing some form of depression during the Covid19 pandemic in June 2020. This had almost doubled from around 1 in 10 (9.7%) before the pandemic;
- One in eight adults (12.9%) developed moderate to severe depressive symptoms during the pandemic;
- Adults who were aged 16 to 39 years old, female, unable to afford an unexpected expense, or disabled were the most likely to experience some form of depression during the pandemic;
- Feeling stressed or anxious was the most common way adults experiencing some form of depression felt their well-being was being affected with 84.9% stating this.
- Over two in five (42.2%) adults experiencing some form of depression during the pandemic said their relationships were being affected, compared with one in five (20.7%) adults with no or mild depressive symptoms.

[71] Coronavirus and depression in adults, Great Britain: June 2020 , Office for National Statistics, August 2020
https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/latest

These statistics also found that women were more likely than men to be experiencing some form of depression during the Covid19 pandemic. Almost a quarter of women (23.3%) experienced moderate to severe depressive symptoms during this time. This compared with one in eight (11.9%) before the pandemic. Looking at the change in depressive symptoms before and during the pandemic around one in six (15.3%) women developed moderate to severe depressive symptoms with a further 8% continuing to experience this level of depressive symptoms during this period. In comparison around 1 in 10 (10.5%) men developed moderate to severe depressive symptoms during this period.[72]

An analysis of the impact of the pandemic on women by the Women's Budget Group[73] showed that:

- A largescale study published in September 2020 found that being younger and female was associated with significantly greater levels of stress, anxiety and depression during the Covid19 pandemic than for other groups;
- 44% of young women with a disability or long-term health condition said they are struggling during the Covid19 pandemic (compared to 27% without a disability or long term health condition);
- 43% of young women feel their mental health had become worse over the last 12 months (compared to 32% of young men) and over 50% said they were worried about their mental health;
- Lone parents (the vast majority of whom are women) were twice as likely to have poor mental health, compared with other family types, immediately before and in the early stages of the crisis. Overall, 51% of single parents reported having depression, bad nerves or anxiety compared with 27% of couple parents.

[72] Ibid
[73] Lessons Learned: Where Women Stand at the Start of 2021, Women's Budget Group, January 2021 https://wbg.org.uk/wp-content/uploads/2021/01/Where-Women-Stand-V5.pdf

The University of Essex[74] has identified that women are more likely to experience a negative impact on their mental wellbeing due to increased family responsibilities, financial worries and loneliness. Research evidence provided by the Women's Budget Group (WBG) shows this burden is even greater for single parents.[75] Some of the starkest differences in the WBG survey were in the rates of high anxiety among mothers compared with fathers, although both represent significant spikes compared to normal data. The WBG states that recovery from the pandemic will not only need to address economic harm but the damage done to the population's mental health and particularly to women's and mothers' mental health.

Cambridge University have also reported evidence[76] that the Covid19 pandemic has had a larger adverse impact on the mental health and wellbeing of some groups than others. Young adults and women have been more likely to report worse mental health and wellbeing during the pandemic than older adults and men. Women reported a larger increase in loneliness during the pandemic, as well as a greater degree of family and caring responsibilities, which could partially account for their higher levels of poor mental health compared to men. This research also found that similar to pre-pandemic trends, adults with low household income or socioeconomic position reported more anxiety and depression than adults with higher household income or socioeconomic position.

Research on the impact of Covid19 on unpaid care work and psychological distress in the UK[77] found that every week women spent 5 more hours on housework and 10

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[74] The gender gap in mental well-being during the Covid-19 outbreak: evidence from the UK, ISER Working Paper Series, June 2020
https://www.iser.essex.ac.uk/research/publications/working-papers/iser/2020-08

[75] Parenting and Covid-19 – Research evidence, Women's Budget Group, Fawcett Society, The London School of Economics and Political Science and Queen Mary University of London, August 2020
https://wbg.org.uk/wp-content/uploads/2020/08/Coronavirus-the-impact-on-parents-20.08.2020.pdf

[76] The mental health impact of COVID-19 and lockdown-related stressors among adults in the UK, Cambridge University Press, December 2020
https://www.cambridge.org/core/journals/psychological-medicine/article/mental-health-impact-of-covid19-and-lockdownrelated-stressors-among-adults-in-the-uk/C1814A3228BCDBA5A9F697C231622628

[77] Gender differences in the impact of the Covid-19 lockdown on unpaid care work and psychological distress in the UK, Baowen Xue and Anne McMunn, UCL Research Department of Epidemiology & Public Health, August 2020

more hours on childcare than men during lockdown. This increased housework and childcare was associated with higher levels of psychological distress for women.

One-third of parents adapted their work patterns because of childcare/homeschooling. Men and women who adapted their work patterns had on average higher GHQ scores (indicating a possible psychiatric disorder) than those who did not. This association was much stronger if he or she was the only member in the household who adapted their work patterns or if she was a lone mother. Only 10% of fathers reduced work hours due to care work compared to 20% of mothers.

Combining employment with increased childcare, homeschooling and housework may have increased feelings of psychological distress through reduced time for sleep and leisure, and the stress of trying to meet competing demands.

This research[78] suggests that lockdown has hit people with young families and lone mothers particularly hard in terms of mental health. Continued gender inequality in divisions of unpaid care work during lockdown may put women at a greater risk of psychological distress. Awareness of continued gender biases in divisions of labour and their impact on psychological health is an important consideration going forward.

A most recent survey by Parentkind showed that 86% of children's and 84% of parents' mental health and well-being have been negatively affected by the disruption to schooling since the start of the first lockdown.[79] Interestingly this research noted that parents in Northern Ireland are far more likely to have been impacted negatively by the current arrangements for their child's schooling than their English counterparts: whilst 84% of parents in Northern Ireland said their mental health and well-being has been negatively impacted 45% of parents in England say the same.

https://osf.io/preprints/socarxiv/wzu4t/

[78] Ibid

[79] Coronavirus Parent Survey Results Northern Ireland, Parentkind, March 2021 http://www.parentkind.org.uk/uploads/files/1/PK%20Survey%20Spring%202021%20NI%20report%20final.pdf

The Covid19 pandemic has resulted in increases in the numbers of women with caring responsibilities and issues with a lack of support for carers. This has had an impact on the mental health of carers. Almost two thirds of carers (64%) say that their mental health has worsened as a result of the pandemic. 65% of women said their mental health had suffered compared to 58% of men.[80]

In addition, prescribing statistics for anti-depressants are on the increase as a result of the pandemic. Anti-depressant prescription rates in the UK are among the highest in Western Europe with prescription rates in Northern Ireland significantly higher than the rest of the UK. Recent figures show that from January to December 2020 more than 2.75million items were dispensed in Northern Ireland compared to 2.5million in 2019 and 2.4million in 2018.[81]

A report by the British Academy[82] has said that major changes to the way society is run in the wake of the Covid19 pandemic are needed to mitigate the impact of the 'long shadow' cast by the virus including an explosion in mental illness. The report highlighted worsening mental health especially among children, low-income households and black, Asian and minority ethnic communities and that this risks embedding long-term problems if the underlying causes are not tackled. With employment expected to rise, the report questions whether the existing social security system, which is geared more towards helping low-paid workers than people without jobs, could cope with a pandemic-induced recession, saying: *"This may prompt reflection on what kind of system the country wants and needs."*

"Covid had a really detrimental impact on my mental health. After lockdown I went really downhill and didn't reach out to anyone until June. I was on the verge of a nervous breakdown and was only sleeping 2 hours a day. Once

[80] Caring behind closed doors: six months on, Carers UK, October 2020 Caring_behind_closed_doors_Oct20.pdf
[81] https://www.belfasttelegraph.co.uk/news/health/concern-as-amount-of-anti-depressants-dispensed-in-ni-rises-40209884.html
[82] The COVID Decade: understanding the long-term societal impacts of COVID-19, The British Academy, March 2021 https://www.thebritishacademy.ac.uk/publications/covid-decade-understanding-the-long-term-societal-impacts-of-covid-19/

they said they were bringing in the army to help I got severe flashbacks to the Troubles and I didn't realise what was happening to me. I was also really worried about my dad who is elderly and was terrified he was going to die. My energy levels dropped and I was very anxious. I went to my GP and they were great and said that I was suffering from severe PTSD through the Troubles. I was started on anti-depressants and my GP phoned me every 2 weeks to talk to me. They eventually offered me counselling as well. Some of the tablets I was put on were addictive so I'm trying to come off them."

"Covid has knocked us way back again."

"During lockdown suicide rates and addictions have increased massively. When we come out of lockdown it will be even worse for mental health."

"Because of Covid if you go and ask for help with your mental health you are not getting it. I think the new virus will be mental health."

"A lot of children's mental health will be severely impacted by Covid – they are not able to express what is wrong with them as they can't express their feelings. God knows in 10 years what those kids will be like."

"I'm on mental health medication and it has not been reviewed in 4 years. I rang my GP and asked for a review but the answer was to give me anxiety tablets. They just keep on giving more tablets as they say they can't change my meds due to Covid."

2.10 Women's Centres work on Mental Health

Many of the Women's Centres carry out a range of work and programmes in relation to Mental Health in local communities across Northern Ireland. This important work has continued during lockdown and many have seen considerable increases in demand for their wellbeing and mindfulness classes as well as for one to one counselling as a result.

Some of the examples of the courses, programmes and services that the Centres provide include the MAS project (see Section 2.10.1) Mindfulness, 5 Steps to Wellbeing, Art as Therapy, Declutter Your Mind, Managing Stress, Mood Matters, Benefit Checker and Financial Support (to support women who have difficulties understanding the benefits system), offering social spaces which are women-only safe spaces for women to meet, talk and make friends and the Centres also have close links with Womens Aid NI, social services, the Probation Board, PSNI, Health

Trusts, Mental Health nurses, social workers, psychiatrists, local churches and community and voluntary organisations to provide holistic services to these women and their families.

The range of services Women's Centres offer can depend on funding and in some cases where funding is not available on the availability of trained volunteers to carry out this work. Some of the Women's Centres have funded provision for counselling but many operate this counselling on a voluntary basis.

Many of the Centres have seen their counselling services grow considerably due to demand in their local areas. One centre, **Chrysalis Women's Centre** in Craigavon, started off their counselling service ten years ago with one counsellor and now have 13 trained counsellors due to demand in the local area. Three of these counsellors have been trained in bereavement as that was the need coming through their doors. They estimate around 40% of their clients are coming to counselling with bereavement issues including loss of children through suicide and loss of relationships.

The counselling service in Chrysalis Women's Centre does not get any specific funding and relies on trained volunteer counsellors. Demand is growing in the local area with the impacts of lockdown, Covid19 and unemployment.

"I think we are just at the start. I think we are going to get a pandemic of mental health issues after the Covid pandemic."

(Ruth McKeever, Manager of Chrysalis Women's Centre, Craigavon)

Atlas Women's Centre in Lisburn has also seen significant increases in demand for their counselling services from people of all ages. They receive many referrals from local GPs, Community Psychiatric Nurses, the Mental Health Team and health visitors. They have nine counsellors and they receive no set funding for any of them, they are all voluntary.

The Centre has seen a lot of mental health issues for parents as a result of the Covid pandemic including isolation, homeschooling and children out of their routines. Many of the women have had new babies and are suffering fear, anxiety, loneliness and isolation. There have been a lot of pregnancies in the area and the mental health of these women has really been impacted because they have not been able to access the same care and have not had continuity of care. Many of the women are experiencing financial worries and some have had small local beauty businesses which have been really affected by lockdown. The Centre is also seeing a lot of relationship issues with separations and cases of domestic violence. They are seeing examples among the women they work with whose mental health has improved in the last number of years because of the services they provide losing this progress as a result of lockdown and a reduced ability to access these important services.

"Atlas women's centre is so important in this area and the services we provide will be needed even more coming out of lockdown. We don't care what women want to do as long as they feel they can come in and have a chat, many of them just want a connection with someone."

(Gay Sherry-Bingham, Manager of Atlas Women's Centre, Lisburn)

Atlas Women's Centre has seen increasing demand for its range of programmes supporting mental health and isolation including arts, crafts, mindfulness, women's wellness and counselling. However, prior to the pandemic they were able to accommodate 250 places per week that will not be possible coming out of lockdown with social distancing and safety precautions impacting on the numbers of people who can access their services. They are concerned about how they will meet demand for their services given the impact on mental health of the pandemic and lockdown.

Kilcooley Women's Centre recognise that health and wellbeing initiatives underpin everything they do in the Centre. They recognise that a person's quality of wellbeing will directly impact on their sense of self, confidence and ability to participate in the

opportunities and activities provided by the Centre. They aim to help people embark on their own journey of personal development whether that's simply to socialise with peers or complete qualifications that will permit them to start or even change their career enabling them to completely change the direction of their lives.

Some of the main contributors to poor mental health include poverty and financial strain, lack of prospects and low opportunities. Kilcooley Women's Centre aims to consistently tackle societal issues by lobbying Government for support whilst countering them by offering food support, welfare packs, more prospects through leaning and education, mentoring, life skills, physical activity and wellbeing enhancement programmes and lots of social opportunities that provide the opportunity for participants to learn and support each other.

The Centre believes it is important to provide low level wellbeing improvement opportunities on a regular basis. In addition, it is key to have good links with other community organisations in order to provide higher level wellbeing support when needed such as financial advice, domestic abuse support and counselling.

One of the most important elements of the Centre's work is recognising the success of every person that comes through the doors of the centre and we do this by hosting an annual graduation ceremony to celebrate all of the participant's successes. Recognition of a person's success plays a major role on their wellbeing.

Kilcooley Women's Centre offer a broad and varied range of wellbeing support programmes alongside low-cost, affordable, onsite childcare because they want to make all opportunities as accessible as possible. This includes Positive Steps (South East Trust mental health programme), STAR (pain management programme), parent support programmes, employability support, food support, education classes, arts & crafts, creative writing, storytelling, drama, gardening and cookery classes, 1:1 mentoring, Chi me and yoga, weight support programme, youth programmes, volunteering and social events for personal wellbeing through activities and events.

"During lockdown many of our classes moved online via Zoom. In order to provide appropriate support we have been making regular weekly calls to all participants to ensure they are supported and can be directed to appropriate services during the pandemic. We also created a local 'lockdown' specific directory for all services across the Borough which was designed to help people by making it easier to avail of services and local support."

(Alison Blayney, Manager of Kilcooley Women's Centre, Bangor)

Women's Centres play a crucial role in relation to mental health services in local communities. The provide trusted, local spaces where women and men can access help in relation to mental help. The services provided are holistic so that the full range of issues that are impacting on a person's mental health can be addressed. Early intervention is an important area of their work to ensure that mental health issues do not get the chance to take hold and cause even greater problems for those impacted. The fact that the Women's Centres provide childcare to enable people to avail of courses and counselling is a major aspect of this work. It enables people to take advantage of help with their mental health without having to disclose to friends/family if they do not wish to do so and removes a significant barrier to access for these important services especially for women.

The Women's Regional Consortium would like to highlight the impact of the work of local Women's Centres in relation to mental health work and its importance to local women, families and communities. We believe that this work often goes unseen in the wider mental health structures and its value is untold. The following testimonials from women who have used the counselling and other mental health support programmes in local Women's Centres highlight its critical importance and value.

"I have availed of the counselling service in Chrysalis Women's Centre on two different occasions, one of those being for bereavement. There was nowhere in the area, that I knew of, that offered this service so when I was told about the centre, I jumped at the chance and rang them. I can honestly say that it was the best decision I ever made. From making my appointment to meeting my counsellor for the first time, I was made to feel comfortable and welcome from the very start. The centre is relaxed and not clinical in any way which

made a massive difference to me, and my anxiety slowly but surely resided. There were no restrictions on the sessions I received, so I stayed as long as we felt was needed. I would never have thought counselling was for me but I guess you never know until you try!"

"This is the Gospel truth but I had really begun to feel I couldn't cope and had stopped taking care of myself. ATLAS is doing a fantastic job facilitating these courses!! I really benefitted from the mindfulness class especially and it has been the highlight of my week because everyone is so open and the tutor brings that out in everyone in a really good way. Her input and instruction has helped me meditate for the first time ever and since learning how to do that I feel more at ease with myself and this has put me back on track again for looking after myself. As a group we have learned from each other sharing tips of what works for each of us and seeing the difference the course has made to others in the group really helps. I now have a mental health toolbox that I can turn to when I need to and I am back exercising again in the mornings."

"I attended the Managing Stress class in First Steps Women's Centre and I absolutely loved it. It has improved my relationship with my 7-year-old and all because of this class. I'm more patient and breathe more. I do not act in anger and I think. This class has really changed me and I'm so grateful."

"I am a 74-year-old woman who has always been considered emotionally strong and the rock of my family. After the death of mu husband whom I had nursed through a long illness, my life went to pieces. After visiting my GP and being unwilling to take anti-depressants, she suggested that I contact a counselling service like CRUSE. However, waiting times for appointments were long and I felt that people who had experienced major trauma were in greater need than me. I just needed to pull myself together and get on with it. Then my daughter informed me that Chrysalis Women's Centre provided a counselling service and she had made an appointment for me. Thank God she did! I thought I would give it a try but I didn't think it would be for me.

It was with some misgivings that I entered the Chrysalis on the first day. The staff were very friendly and welcoming and the counsellor was very soft spoken and immediately put me at ease. My first visit was just like chatting with a friend and I promised I would be at the next session to my surprise. Over the following sessions, I spoke of things I had not dealt with in my past. Some days it was hard as past hurts, regrets and disappointments all came tumbling out. But I still kept coming back. Slowly over a series of sessions, I began to be me again. I had lost my identity over the years by putting others first and now it was time to live my life the way I wanted.

I entered counselling lost and broken and by the time I left I felt like a whole person again. I am still a work in progress but thanks to counselling and Chrysalis, I have the tools to cope with whatever life throws at me."

"I thoroughly enjoyed the mindfulness course at First Steps Women's Centre. I enjoyed meeting new people and how it helped me to get over and deal with past life challenging issues."

"Over this Zoom time I really enjoyed attending the classes at Atlas and looked forward to them with the whole lockdown going on. You look forward to that connection in your day and I noticed the days that I was doing something with Atlas I came away feeling positive and good and I noticed a real difference (drop) in my mood the days I wasn't having a class or that connection or interaction. The Declutter Your Mind and 5 steps to wellbeing classes reinforced things I already knew about by keeping it in my mind to exercise, be in contact with people and eat healthy. That reinforcement reminded me to do these things to keep me positive."

"Through the courses at First Steps Women's Centre I have taken small steps to a better life. It's a work in progress. The Centre is friendly and inviting, thank you all."

"Through Falls Women's Centre I've learned resilience and to stand up for myself. I was very nervous and shy. The Women's Centre taught me confidence, to socialize and to meet people. I came from a really bad place following abusive relationships. I was nervous about meeting people. It helped bring out positive things – educating myself, wellbeing classes, etc."

"When I first came in the door of Falls Women's Centre I knew no one, I live alone. It had an immediate impact they were so welcoming. Only for the Women's Centre during lockdown I don't know where I'd be. I do classes via Zoom now and while it's not the same it still helps."

2.10.1 The MAS Project

The Maternal Advocacy and Support (MAS) Project is designed to promote positive mental health and wellbeing for women who are pregnant or have children aged 0-3 years, by offering women the opportunity to share experiences, engage in activities and express their views.

The project which is run by Women's Regional Consortium partner WRDA has received three year funding from the National Lottery Community Fund following a successful six-month pilot project.[83] The project works with eight local Women's Centres (Windsor, Falls, Footprints, Ballybeen, Greenway, Atlas, Women's Centre Derry and Strathfoyle) to create a network of peer support groups for women experiencing perinatal mental health issues. The MAS network will also support women from disadvantaged communities to tell their story and participate in decisions that will improve perinatal mental health services.

Research indicates that women from low income households are much more likely to be diagnosed with post-natal depression than those from more affluent backgrounds. In the pilot project many women said they feel it is harder for them to ask for help because they fear that a mental health issue could lead to social services involvement.

Throughout the three-year project WRDA will work closely with Aware NI who will provide specialist training and support to MAS Project staff and they will deliver the Mood Matters, Mother and Baby programme to participants in all eight Women's Centres. WRDA's aim is to bring the voices of women from disadvantaged communities into the heart of the campaign for better mental health services for mums.

2.11 Access to Counselling

Access to counselling is very important. For many people it is the only answer to their mental health issues and they place great value on it. However, access to counselling can be patchy and many people have to wait a long time to get the counselling they need. Others found that GPs were more willing to offer medication for mental health issues rather than counselling.

[83] Promoting Positive Perinatal Mental Health through Women's Centres Evaluation of Pilot Project, WRDA, July 2019
Mas-pilot-evaluation.pdf (wrda.net)

The availability of counselling through local GP surgeries is a way to ensure that this service is available across Northern Ireland and at community level. This counselling must be specific to the needs of the individual and provided by someone who has relevant experience in mental health issues.

"Counselling was my saviour and my employer put that in place for me. Counselling is an amazing thing but if you get the wrong person at the very start it can put you off for life and your trust in the process is broken. You need people who are experienced and trained in the relevant areas."

"There should be counselling services available, not just a general one where they send everyone no matter what their issue is but which can deal with specific issues. Everyone's experience is completely different and no two stories are the same. Counselling can be the best and worst journey you are going to take in your life."

"I was diagnosed with severe anxiety and depression and I had a nervous breakdown 10 years ago. I work in a very supportive place and I'm a very outgoing person. I couldn't go to work for 3 months, I spent 8 weeks inside the house and wouldn't let anyone in. I went to my GP three times in one day my mental health was so bad. I was squealing that my medications were not helping. I was on several tablets, anti-psychotics which just left me more psychotic. I had to fight back myself. I ended up getting counselling through work which I couldn't get through my GP. It helps when you are being counselled by someone who knows what it's like to be in that position as they are in the best place to help you."

"You need to talk to someone who knows what it feels like to go through what you are going through."

"It's really important counsellors have a background in mental health."
"The first time I took my son to the GP the first thing they offered was pills but he didn't want to take them. That's not the only answer for mental health problems."

"I had a still born baby at full term and my mental health went very downhill after that. I needed counselling early on but I went to my GP and was prescribed anti-depressants. I was on them for 6 months. I really wanted counselling but the waiting lists were so long. The tablets took all the emotion away from me and I didn't want to be on them. My mental health got worse during the wait for counselling. I eventually got referred to CAMHS and got

CBT but it didn't really help me. Then I got referred to Cruise which was counselling specific to bereavement and it really helped me it was what I needed. I was able to come off the tablets after eventually getting the counselling I needed. I think GPs don't have enough experience with mental health. I needed an experienced counsellor. I saw a young doctor who had only started and he didn't know how to react to me crying – he didn't have the training to deal with it like a counsellor would have. I think that baby loss is such a taboo subject and nobody wanted to talk about it."

2.11.1 PPR #123GP Campaign

The Women's Regional Consortium supports the statement from PPR calling on the Minister for Health to include the following text in the Mental Health Strategy:

Ensure that mental health counselling is available to all, regardless of where they live.
All counselling provision will be quality assured, adequately resourced and of sufficient duration to meet individual needs.
If counselling is the agreed best form of support for a person, they should have to wait no longer than 28 days for a first appointment and no more than 2 days for an urgent appointment.
The role of local community-based providers in providing timely and accessible counselling will be fully recognised and resourced.
Delivery options will include face-to-face, telephone and online provision through an adequately resourced, in-house GP counselling service and/or recognised community-based provision.

We urge the Department to consider the rationale provided by PPR which echoes much of what women told us in focus group sessions about counselling:

The Covid19 pandemic has impacted significantly on the mental health of our entire population. Pre-Covid inequalities means that these impacts are being disproportionately experienced by certain groups of people. As the work of rebuilding

health services begins, GP practices continue to be the first port of call for people struggling with their mental health. It is vital therefore that all GP practices are adequately resourced and equipped to provide people with timely and appropriate support. Getting the right help at the right time in the right place can make a critical difference.

Early intervention can help prevent the escalation of problems and can prevent people from spiralling downwards or from ending up in secondary mental health services. Counselling is one, effective, non-pathologising treatment option for problems such as anxiety and depression. It can be effective alongside medication, other therapies including alternative therapies, or on its own. This is particularly important in our society, where prescribing rates for anti-depressants have increased exponentially in the past ten years.

Unfortunately, the evidence shows that timely access to counselling is not as it should be. While many GP practices do provide in-house counselling, access continues to be a postcode lottery, almost entirely dependent on where you live. This is clearly unfair. The Talking Therapy Hubs, another referral route for GPs, are not available in significant parts of the population. Again, this is inequitable.

The draft 10-year Mental Health strategy sets out a vision that ensures consistency and equity of access to services, regardless of where a person lives, and that offers real choice. We acknowledge that the Strategy includes plans to transfer Talking Therapy Hubs into primary care and to integrate them within Multi-Disciplinary Teams (MDTs), aligned to GP Federation areas. With only 6 of the 17 GP Federation areas currently equipped with MDTs this clearly will involve a longer-term re-organisation of services.

People however, do not have the luxury of waiting another 6 months, a year or even longer. This Strategy must address and fix the problems with access to counselling in the immediate term. People need to know that the postcode lottery will end and that everybody who needs to, will be seen in a timely manner.

Thankfully, solutions exist that can be readily implemented. We have a model of provision, GP practice-based counselling, that is already working and that can be further developed. We have a sufficient supply of trained counsellors to meet the increased need as a result of Covid-19.

Local community-based counselling services have historically been under-funded and under-valued. They are trusted by local people and have excellent capability, capacity and know-how, built up over many years. They are well placed to respond quickly and professionally to local people's needs.

The pandemic has opened up solutions to barriers, including physical space, through the options of telephone and online provision.

Counselling Works. Let's end the postcode lottery and ensure that counselling is available to all, in a timely manner, regardless of where they live.

Consultation Questions

Personal details		
Name	**Siobhán Harding**	
Email address	**policy@wsn.org.uk**	
Are you responding on behalf of an organisation?		**Yes** *(delete as applicable)*
Organisation *(if applicable)*	**Women's Regional Consortium**	

Vision and Founding Principles
Do you agree the vision set out will improve outcomes and quality of life for individuals with mental health needs in Northern Ireland? **Mostly Agree**
Please add any further comments you may have: We agree with the vision set out in the Consultation document. We note how the vision addresses a number of important issues in relation to mental health including promoting mental health across a person's lifespan, reducing stigma, the importance of consistency and equity of access to services, breaking down barriers, putting the needs of the person at the centre, ensuring people have access to the right help and treatment at the right time and in the right place, compassionate mental health service and enabling people to achieve their potential. These are hugely important and central issues to the success of any Mental Health Strategy and we fully agree that action around these issues will improve outcomes and quality of life for those suffering with mental health problems. However, values should not be a replacement for action and real, achievable rights which can be accessed regardless of where a person lives, their characteristics or mental health problems. Visionary statements are important in setting the context for service provision but should not be replacement for rights and action that people can rely on to make a change in their lives and to enable them to achieve their potential. Evident in the need for actions to support this vision is the need for funding to achieve these actions and make the vision a reality. Without the actions and funding to support this vision then it will not improve outcomes and quality of life for those with mental health here. We also believe that the community and voluntary sector must be closely involved in the co-design of all the actions within the Strategy. As currently proposed the

Strategy has a very strong statutory focus. It is impossible to be truly effective in tackling the issues of mental health alone, it can only be achieved in partnership with all sectors.

Do you agree the founding principles set out provide a solid foundation upon which to progress change?

Mostly Agree

Please add any further comments you may have:

We agree with the founding principles. We believe it is hugely important to listen to the voices and experiences of local people so that the system can be responsive to their particular needs and the needs that exist specific to Northern Ireland.

"The more people who give a voice to mental health issues the better off this Strategy will be."

Our evidence from local women reinforces the need for a person-centred approach to mental health rather than forcing them into rigid systems which do not meet their needs. This is highlighted in the quotes and case studies of women throughout this response.

We particularly welcome the principle of recognising and addressing the specific needs of particularly at risk groups of people and the barriers they face in accessing mental health services. We are firmly of the belief that services, policies and actions should be targeted at those who are most at risk. In terms of women we provide an example of how not addressing the specific needs of at risk groups is harmful. A gender-neutral approach to policy and decision making has been the standard across Government and this has not served women well as it fails to take account of the different experiences of men and women as a result of existing gender inequalities. A failure to account for these gender dynamics means that the design of policies and budgets can aggravate existing gender inequality and may not benefit women and men equally. The issue of gender neutrality is a significant barrier to women's equality.

Theme 1: Promoting wellbeing and resilience through prevention and early intervention

Do you agree with the ethos and direction of travel set out under this theme?

Mostly Agree

Please add any further comments you may have:

We believe that prevention and early intervention is hugely important. This enables actions to be taken early before mental health problems are allowed to take hold which have such negative consequences for sufferers, their families and communities.

"Early intervention is key."

Do you agree with the actions and outcomes set out under this theme?

Mostly Disagree

Please add any further comments you may have:

Early intervention is crucially important and many of the women we spoke to about this consultation agreed that this is vitally important.

However, the Actions under this Theme have a strong focus on statutory provision and there is no mention of the community and voluntary sector who carry out much of this early intervention and prevention work (see Section 2.10 for the impact of the work of the Women's Centres in Northern Ireland). It is concerning that this valuable work which takes place in trusted spaces at community level and which often reaches the most marginalised, in a way that statutory services cannot, has not been mentioned in any of the Actions.

Action 1
Creating an action plan does not commit to anything other than creating a plan. There is a need to ensure that the actions within this plan are committed to for this to be effective. It must not be vague and non-committal.

An action plan only points to help but if it is under-resourced it will not amount to anything. There is no point in putting it in place if it is not actually going to make a difference for people. Concerns about how the success of the action plan would be measured were also raised. This is an important issue in terms of measureable and substantive progress.

"Create an action plan then ACTION the plan!"

"Quite a few of the actions are not concrete in the Strategy – how will they be measured? How will they say they are successful? If they increase statistics by one person will that be counted as a success?"

We welcome the fact that **Action 1** states that more help should be given to certain groups that have more mental health problems. However, there is a need for more detail around this so that the statistics can clearly show who is disproportionately affected. There are also issues around access to disaggregated

data in many areas. Accurate and reliable data disaggregated by all Section 75 groups is necessary to determine where the focus of action should be.

There are also issues around under-reporting of mental health problems in general. This may lead to a distortion of where the focus and attention should be directed and must be a consideration for the Department. For example, maternal mental health statistics are under reported and a low level of identification by universal services has been one of the greatest barriers to families receiving help.[84] Maternal mental health is a significant issue for women yet there is a lack of screening and time devoted to identifying this issue.

Women highlighted how difficult it was to come forward about a mental health issues and many may only do this when things are really bad for fear of issues like social services involvement, etc. A lack of screening and time devoted to mental health meant that it was not easy to identify or come forward with these issues. Women suggested there was a need to make it easier to disclose mental health issues across the board to help with early intervention efforts.

"Mental Health issues are difficult to disclose. People find it difficult to disclose mental health issues – there is already a lag in getting in front of a doctor to say you need help."

"It's really difficult to reach out about mental health and many only do this when they are in dire straits. Then they are maybe given an appointment which is 18 months away – it's no good to them then."

"People fear the consequences of coming forward with mental health issues such as social services intervention, etc."

"It sometimes takes a lot of courage to ask for help."

While men are more likely to die by suicide, women are significantly more likely than men to make a suicide attempt.[85] Within the LGBT community, 25% have attempted suicide.[86] Studies indicate that the higher odds in suicidal attempts are also true for transgender people compared to cisgender. This illustrates the need to take a detailed and careful analysis of statistics to ensure the complete picture of the issue.

"Women are more likely to develop mental health issues – it is often framed in the public discourse that men are most impacted because they are more likely to die of suicide but it's about more than just this."

[84] Time for action on perinatal mental health care in Northern Ireland, NSPCC, November 2018 https://learning.nspcc.org.uk/media/1584/time-for-action-perinatal-mental-health-care-northern-ireland-report.pdf

[85] Understanding suicide and suicidal behaviour in Northern Ireland, Knowledge Exchange Seminar Series 2015-16, Northern Ireland Assembly siobhan-oneill-policy-briefing.pdf (niassembly.gov.uk)

[86] Have 1 in 4 LGBT persons attempted suicide? – FactCheckNI

Action 2
At consultation events caution was suggested over the word 'hub'. This is a term very often used by Government in looking at the population and dividing it up to determine where to put services. It often means that services are located in Belfast and Derry with a few other 'hubs' in some of the larger population centres. In some instances this means that people still have to travel 40 – 50 miles to get to the nearest hub and this is very often an issue for rural people – see Section 2.2.

There are issues for access to public transport in Northern Ireland and this can disproportionately impact those in rural areas or those on lower incomes. If you are struggling financially and have mental health issues you may have great difficulty getting a number of different buses to get to an appointment in a hub.

Women pointed to the PPR campaign (see Section 2.11.1) which would allow access to counselling through your local GP. Women felt it was better to get therapy locally and this would particularly benefit those living in rural areas. Many women were very positive about counselling and its value to those suffering from mental health issues but had concerns about access and waiting times. They also suggested the need for supports immediately after counselling sessions as well as further support after counselling is over to help people work through the next stage.

Women pointed to the counselling provided through Women's Centres as being very positive (see Section 2.10). They also suggested that access to other holistic therapies and wellbeing classes would also be very beneficial alongside counselling.

This Action while positive is not concrete. It does not detail the percentage that talking therapy hubs are going to be increased by it merely uses the work "expand". We believe that this Action should include targets so that a small increase cannot be claimed as a success. In general women felt that this Action was too vague.

"Counselling is positive but maybe for a longer period. 6-8 weeks is not enough and once it's done that's it. After finishing counselling there is a need to provide something else so that you feel like you are not just left there – something to build the skills you need for the next stage. You have worked through something in counselling and need to work through the next stage to bring you on a bit further. Something where you can learn the skills you need and put them into practice. More support/befriending services, etc."

"I found it very hard after coming out of counselling to cope – I was sent out and I didn't know how to deal with what had been opened up. My way was to rebel and get into trouble. I had no one to go to/talk to. It opened up a lot of stuff for me and then I got in trouble after the sessions."

"You have counselling for 6 – 8 weeks and then that's it you are just left there. The Women's Centre has been my lifeline through the courses and counselling they provide. There is not enough funding there for people who are coming out of counselling – you are just thrown out into the street after it's over."

"Every GP practice should have a wellbeing clinic. It makes a real difference to people and they feel so much better after treatments. There is no funding for this. There needs to be somewhere in each GP practice for a wellbeing clinic which is attached to the counselling service."

"Holistic therapies are needed as well as counselling. These therapies can really help to make people feel better."

Action 3

Women at focus groups highlighted that most schools have counsellors but trying to access them is difficult. It is often hard to access any help this way as there is a huge demand even before the pandemic.

There are also issues fitting in counselling around the school timetable which can sometimes undermine the purpose of counselling. If you are vulnerable after counselling and have to go back to the classroom afterwards it may not work for you. Provision in schools must be uniform across Northern Ireland and be suitable to the needs of all children including access in different languages.

Women felt that young children's mental health should be focus in the curriculum so that wellbeing is promoted at an early age and not turned to in later life when problems emerge.

Provision in schools for mental health and wellbeing is not standard across all schools. Women gave examples of schools who provide meditation and have a focus on wellbeing but that this can be dependent on the individual school and their priorities and is not the case across all schools.

"There should be a requirement to work wellbeing and mental health into the school curriculum – its needs integrated into the curriculum it's so important."

"Mindfulness should be part of education in schools. It is good because it gives you coping mechanisms and it can be done from a young age. It could be incorporated into the school curriculum and young kids are taught how to deal with their emotions when they become overwhelming. This could result in more positive outcomes rather than negative ones such as self-harm, eating disorders, etc."

"I think it would be amazing for mental health to be taught in schools. Starting from P5, 6 and 7 and then into secondary school when things get harder. There is no one as cruel as children and helping them to cope with

all the issues they face such as bullying, social media and sexual activity would really help. They need to be aware of their feelings and how to cope with them."

"I think that if I had got support when I was young it would have made a real difference. If I had been taught how to cope with mental health issues. The only thing we got about this in school was maybe a powerpoint on mental health once every three years and told about the school counsellor. But the school counsellor just told me that I was having negative thoughts and that didn't help."

"If support was there in the first place you wouldn't have this domino effect. There needs to be proper supports in place for people at the start."

There are significant problems in Northern Ireland with access to childcare and this has been highlighted by CEDAW who have recommended that Government should ensure the availability of affordable and accessible childcare particularly in Northern Ireland.[87] This means that not all children have the same access to early years provision. With just 12.5 hours per week of funded childcare per week, Northern Ireland is falling behind other areas of the UK in terms of childcare provision which can be important for children's early years development.

Action 4

Again access to specialist mental health services is not standard across schools and there are long waiting list for assessments (and therefore diagnosis) for issues like ASD and intellectual disabilities.

Provision is patchy. One mother who is waiting on an assessment for autism only felt it was given attention when her child got to a certain class because the teacher had a special interest in it. Before that she was just left to try and push it herself. Another woman felt that assessments happen more quickly if a child is disruptive. If the child is not disruptive they are just left to get on with it. In some cases women gave examples of diagnosis taking over four years.

Many of the women involved in consultation events spoke about their constant fight to get assessments, support and services for their children and how difficult this was not only for their child but for them as parents.

"Lots of people say my son doesn't look like he has a disability. He is autistic. I'm fighting all the time for his education in school. It's always a fight, I'm always having to explain myself because his disability isn't obvious. People who care for people with mental health issues go through

[87] Concluding Observations on the eighth periodic report of United Kingdom of Great Britain and Northern Ireland, CEDAW/C/GBR/CO/8, March 2019, para 45 https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GBR/CO/8&Lang=En

the same thing. It's very hard when a disability is not obvious. I am constantly having to advocate on behalf of my child."

"My daughter suffers from anxiety and depression. She is quiet and not disruptive but in school she got nowhere as there was no support available for her as they didn't have the resources. I ended up having to take her out of school because there was no support available for her there. I got her into the local women's centre but it is only because I have connections in the local community. There needs to be more resources for schools for the children that are able to go to mainstream school but find it hard to manage."

"We do not have the same assessments in NI as they do in GB to assess things like autism. The services don't exist here and there is a lack of understanding of people's needs and this makes carers lives difficult – no one understands."

"My children have disabilities. My son has high functioning autism but was basically left on his own. It was a fight for 9 years to get some support for him."

Women felt that there was a lack of detail in this Action. It does not contain specific timeframes for assessment or diagnosis.

Whilst calling for specialist services is good it must be recognised that gender norms can prevent women from coming forward leaving them living in chronic pain and getting no help. In some cases women's behavior is just dismissed. For example, it is impossible to get a diagnosis of ADHD as a woman often diagnosed with chronic depression instead. Diagnostic criteria if often based on boys and men. Women are not included in the criteria so GPs don't look for signs specific to women. Ignoring women's experience in this way turns their issues inwards instead of turning them outwards. This means that many girls with ADHD go on to have eating disorders, etc because they have turned their frustrations inwards.

Womens trauma is often diagnosed as emotionally unstable personality disorder (EUPD or Bipolar II) which people are calling the modern day hysteria as a means of dismissing women. It was felt that there was too much focus on putting a label on people rather than focusing on the trauma that they are experiencing.

"My friend got an autistic diagnosis aged 25 but she had to pay privately for it. As a teenager it was not picked up. This led to huge issues for her and she dropped out of school. She was put on medication for borderline personality disorder – which is a disproportionate diagnosis given to women. This led to 10 years of severe illness for her and she experienced negative impacts and trauma through not being diagnosed. Her teenage life was ruined as a result."

We refer to the information contained within Sections 2.5 and 2.7 on the links between poverty, debt and mental health issues. These are important considerations at all stages of the Mental Health Strategy and must be considered as part of prevention and early intervention work. Enabling people to live their lives free from poverty and debt and the negative impacts of these can be an important part of preventing and alleviating mental health problems. This would involve the need for a properly supportive social security system as well as resourcing for advice and information in relation to benefits and debt.

We also refer to the information contained in Section 2.10 on the impact of the work carried out by Women's Centres across Northern Ireland in relation to mental health in local communities much of which is centred around early intervention and prevention.

Theme 2: Providing the right support at the right time

Do you agree with the ethos and direction of travel set out under this theme?

Mostly Agree

Please add any further comments you may have:

We agree that providing the right support at the right time is very important and it is also important in trying to ensure that mental health problems do not worsen which is costly not only to the individual and their families but to wider society.

Do you agree with the actions and outcomes set out under this theme?

Mostly Disagree

Please add any further comments you may have:

Once again we find the Actions under this Theme very statutory focused even though there are a great many community and voluntary organisations who provide a great deal of valuable work in these areas. Yet in the 20 Actions within this Theme there are only two that mention the community and voluntary sector.

Actions 5, 6 and 7
CAMHS is currently under pressure and there is no doubt that it needs significant investment but this investment must be meaningful and produce results. The long waiting lists point to the demand for the service but it is important how this money is spent. If it is offering 6 hours to talk to a teenager but by the time they have opened up enough they are 5 hours into what they can access this will not provide the help needed by that teenager.

It must also be noted that the help provided through CAMHS may not benefit every young person that it is offered to and therefore a one size fits all approach should not be taken through this approach.

"My teenager daughter goes to CAMHS as she self-harms. I went to my GP and said she was suffering from depression and was self-harming. She then had a suicide attempt. I had to phone up every time something happened to ask for help. I asked the social worker to get involved but no one was listening to me as her mum. She was eventually referred to CAHMS and has had some appointments in lockdown but she had her last appointment in February and 7 weeks later has not had another yet it is supposed to be every 2-3 weeks. I have to keep chasing it. She is out of school now due to Covid but when she goes back she is likely to crash with all the anxiety."

Action 8

It is positive to see that the draft Strategy addresses the needs of people over 65. However, there is no mention of the issues for those over 65 in care home settings where mental health issues can also be quite high. This group is harder to reach and may be more invisible so it is important that they are a specific consideration within this Action. Plus, there may be issues depending on the quality of the care home with those in "better" care homes having their needs in relation to mental health met while those in "poorer" homes may be neglected. There needs to be guaranteed access to mental health services in all care homes so that those who need help can access it no matter where they live.

Actions 9 and 10

We agree with the intention to ensure a person centred approach throughout the whole of this draft Strategy. We have heard some good feedback about Recovery Colleges anecdotally but do not have enough evidence to give informed comment on this Action.

"A person centred approach is always best. Instead they seem to follow the same route with everyone. Help needs to be person centred. Currently the way help is given through GPs just feels like a flow chart they are following but is not specific to the person."

"If you have any other illness such as cancer they are not going to send you to a cardiologist to look after your cancer. It is the same principle with mental health. All other care is centred around what is wrong with the person except mental health".

"Person centred approach is the only way to go. If it can be tailored towards the person as much as possible it will make a difference. So one person will want counselling and not meds and another may want meds and counselling. Each person's needs and experiences are different and they should be treated differently."

Action 11
We wish to acknowledge and pay tribute to the valuable work undertaken by the community and voluntary sector in relation to mental health. We refer to Section 2.10 for information on the help provided by the network of Women's Centres in Northern Ireland which is so vital to the women they serve. We believe that this work is undervalued and unseen by Government and therefore grossly underfunded given its importance to women's mental health and by extension their children and wider communities.

Funding is a massive issue for the community and voluntary sector. Many of these organisations rely on short-term funding which does not allow for job security or the retention of knowledge and experience in the sector. Continuity of delivery is vitally important in that a need is generated when a project is set up and if this ends due to lack of funding it can leave those who are the most vulnerable without the help they so desperately need and could potentially impact on their recovery.

While we would like to see the valuable services provided by the community and voluntary sector acknowledged and integrated into the wider service delivery we would be concerned that responsibility is foisted on the community and voluntary sector without adequate funding and support to be able to do this important work.

"I would be lost without Falls Women's Centre, they have dug me out of more holes than I care to remember. I've gone there in tears and they have helped and supported me. I miss the craic in the Centre now because of lockdown."

"More funding is needed for Women's Centres who do so much for so many and often it is not heard about or valued. They can get the help to where it needs to go as they see the need on a daily basis. They are probably better than the doctors!"

"I wouldn't be here today only for the counselling and training provided by Falls Women's Centre."

"Everyone has a story and we're all there together to help each other out. I live on my own so it's a big thing for me to be able to get to Falls Women's Centre, I would be lost without it."

"More funding is needed for women's centres. Without them I don't know where I would be."

"It helps me to have a chat and to listen to what other people have to say and there's no judgement in the Women's Centre. Women need women! To understand and guide them. Sometimes someone else's experience helps someone else – a problem shared is a problem halved."

"My mental health is better even talking together helps. Some people may need more than coffee and a chat but getting together really helps me.

Women's Centres are so important as they help people get together and talk and can also signpost if there are more serious issues and further help is needed."

Actions 13
Women felt that it was good to have an option of digital services available and it has the potential to be preferable for some people maybe younger people particularly. However, there are issues for people in rural areas with access to broadband and for older people who may not have the necessary skills to cope with an online process. There are also issues for low income groups who may lack access to the necessary technology with which to access help in this way.

The infrastructure is not there to support more healthcare online. It is a good option but should only be one of a number of options available. While it is good to have this option available it should form a small part of primary/secondary care.

There are also issues with diagnosing online and women stressed there was a need to differentiate between therapy and diagnosis. Many felt it would be impossible to diagnose online as it relies so heavily on body language.

So much has moved online because of Covid. The experience of many of the Women's Centres is that while they have offered mental health courses and sessions via Zoom during Covid it is always better to carry out this work face to face most especially for women who are new to their services.

Women also stressed that it is not possible to deal with more vulnerable people online. Concerns were expressed about how you leave someone after they have finished with an online call. There is no support there.

This option must be by choice rather than the go to option. It was suggested that GPs could help decide who might be best to avail of this. It is often the case that people feel out of control by the time they seek help for mental health issues so this should not be forced on them if they do not wish to access help in this way.

Actions 14 and 15
There are links between poor physical health and poor mental health so there is value in this but there are also risks. Women gave examples of how this can be negative. For example, one woman said that because she is overweight everything from an ingrown toenail to a mental health problem is blamed on her weight. There are concerns that physical health is put first before mental health and women reported that they felt that physical health was always given a higher priority. There is a risk that the physical element is more likely to be the primary focus of the visit to health services and therefore that the mental health aspect can be ignored, minimised or brushed off as a consequence of the physical issue.

"I feel that there is almost a discrimination there between those who care for people who are mentally ill compared to those who are physically ill. I feel

that those with mental illness are discriminated against and treated like it is less."

Women gave examples of people with weight problems being told by their GP to go for a walk and that would help with their weight and their mental health issues. There was concern that the focus on physical health would make it easier for GPs to link the mental health issue to the physical health issue by suggesting that for example, losing weight would make someone feel better.

"I am overweight and when I go to the doctors their first response is always my weight. If you are overweight and have a conditions they don't look past that. My sister is slim and she had the same condition as me – it was diagnosed for her but not for me as the focus was on my weight."

Women reported how frustrating it was that physical health issues are used to diminish mental health issues. There was a feeling that some GPs do not look at the whole body and how it is interconnected. For some GPs it is as if the physical disabilities must be to blame for the mental health issue – they are what is making the person feel bad.

The issue of training for GPs on mental health issues was also raised. It was felt that many have very little training on mental health with a focus on physical health. Women felt that GPs do not receive enough training and support in the area of mental health. The training they do have is around less serious mental health issues such as low mood. The suggested fixes often involve going for a walk or talking to people but this does not help with more serious mental health issues. GPs can also make generalisations about people so that if someone presents well (wearing make-up and well dressed) that they must be OK. GPs want and deserve better training around mental health. Training for GPs should not just be at University but through Continuous Personal Development so it is ongoing and updated throughout their working lives.

This is an important issue as a negative experience when disclosing a mental health issue can be a major deterrent in coming forward again. If your first disclosure is negative you are unlikely to speak up again. There is a need to look at the whole person and all of their health conditions.

Women felt that GPs do not understand perinatal mental health issues and this has led to women getting very negative and dismissive attitudes from GPs.

There is a need to look at the whole person and all their health conditions.

"If you are put off and told to lose weight then you won't want to go back to them about your mental health issues as you think they won't be taken seriously."

"I was 5 months pregnant and already had two children. I took severe pre-natal depression. My GP was my only port of call, I didn't feel I could talk to

anyone else about it not even my family. I was told to get a Hello magazine and go home to bed. That is my experience of how my GP dealt with mental health. I used to wake my husband at night and ask him what was I going to do. It was the worst time of my life. I just had to suffer it myself I just didn't know what else to do. It just affected one of my pregnancies and I had more children after that and I was fine. There were just no services for pre-natal mental health then."

"When my baby was born I had post-natal depression. I spoke to my GP about it and they said they would phone me back. I'm still waiting on the call and my son is 9. I just had to deal with it by myself."

"It's difficult if you get a doctor that doesn't understand. Some have no time for anyone. They try and tell you what is going on in your head."

"I got a young doctor reading who was just reading from a book – she doesn't see what's going on in my head."

Actions 16, 17 and 18
There has been no confirmation of funding for a mother and baby unit in Northern Ireland. This must be prioritised to ensure early intervention with mums so they can recover with their babies.

Women suggested that there are issues with people who have mental health problems being treated in very old and run-down buildings. This inevitably leads to a stigma around these services.

We point to the figures quoted in Section 2.4 about inpatient beds and the demands for adult mental health services.

Action 19
Women reported that people often find it difficult to access help in a crisis and many end up at A&E. There is a lack of awareness of the path to access help in a crisis.

"In a crisis you have to go to A&E and sit among other people while your heads away."

"If there was somewhere to go that is not A&E so you are not sitting for hours on end."

"How many people have walked out of hospital and have hanged themselves because they haven't been helped."

"I would like to see purpose built places for mental health so you don't have to sit in A&E – somewhere to go where there is no stigma."

Those with serious mental health issues are likely to have presented in a crisis many times. This may lead to them not being taken seriously.

"They sometimes treat you like you are still alive so it's not really a crisis."

The Crisis Team is under pressure and women were of the view that there is some element of gatekeeping for access to its services by GP staff. Some people are being told they are not really in crisis and should just wait on an appointment coming up with their GP. In some cases the receptionist decides who can access the GP. A lack of training among GP staff can cause problems and there is a need for training in relation to mental health issues and effective signposting.

There is a stigma around mental health and often staff in smaller rural practices are local and are known by patients – see Section 2.2. This can make it really uncomfortable to disclose mental health issues and particularly more serious issues around a crisis. A small town mentality can prevent people from fully disclosing what is happening to them. Reducing the stigma around mental health would help with disclosure.

Action 20

There is clearly a deficit in addiction treatment services. There are some charities doing work in this area but Northern Ireland does not have the services that other parts of the UK have. There is a need for residential services for addictions.

Women noted the prevalence of prejudicial attitudes towards addiction. There is generally a lack of understanding around addictions and the links between trauma and addiction. People are not turning to addiction because they have nothing better to do they are often using it to cope with some kind of trauma in their life. There is a lot of victim blaming in relation to addiction with a view that if you want a comfortable life you have to work for it and if you don't then you get what you deserve.

Addiction is often seen as a moral failing rather than a mental health issue so people are viewed as getting themselves into it. However, if you help people with their addictions you can help them with so many other issues also.

"There is not much help on the NHS for addictions – what actual support is available through the Trusts?"

"If you go to doctor/hospital with a mental health issue and you are taking drugs or have an addiction they will put it down to that and tell you that you need to come off it but they don't help with the mental health problem."

"Addiction teams can be no help – you have to be clean to get help."

Action 21, 22, 23 and 24

We understand that services for addiction are mentioned in Action 20 however we believe that this must go much further than diagnosis. There is a need for

specialist addiction services in Northern Ireland as referenced above and we believe that this should also be addressed in this section.

We very much welcome that the long awaited funding for a specialist perinatal mental health services has been approved. This service will make a huge difference for women in Northern Ireland. However, the criteria is very strict to access it meaning that only women who are very seriously unwell can access these services. This still means that the majority of women are managed outside of this. There is concern that those who are outside the criteria for this service will suffer from a lack of support which can lead to other problems such as addiction. It is clear that a lack of diagnosis in this area can lead to more long term problems.

Services to help with eating disorders are seriously underfunded and Trust based services are stretched and under pressure. This leaves many people unable to access the support they need. Once again early identification and intervention is important in this area. As the draft Strategy recognises this is an issue that disproportionately impacts on women. There is a need to provide sufficient funding to specialist eating disorder teams to ensure the availability of these services.

While the women we spoke to welcomed these Actions they asked the question *"Have we come into money?"* These are all important issues and the need for specialist interventions is clear given current demand but these Actions will not be realised without sufficient and consistent funding to allow for this.

We wish to raise a number of other areas where specialist interventions may be required:

- Domestic Violence situations – domestic violence often involves a pattern of coercive control and manipulation that can lead to extensive mental health trauma including a loss of self-esteem, depression and isolation. Victims of domestic violence may require specific and tailored mental health services. These services should be provided by people specifically trained in the dynamics of domestic violence. This is of particular concern due to the impact of the Covid19 pandemic which has caused significant increases in the numbers of domestic violence cases.
- LGBTQ+ - there is a need for adequate funding and specialist help for those within LGBTQ+ communities who are at increased risk of mental health issues – see Section 2.4. There is a need to engage in meaningful co-development and co-production of training and service provision with LGBTQ+ communities. Mental health services for these communities should be delivered in collaboration with the community organisations which often provide trusted spaces for these communities.

"We need to be looking at mental health. We don't have enough specialist mental help available. It's not just about the conflict it's about all mental health issues. There needs to be somewhere for sufferers to go. Putting them in a waiting room in a hospital isn't good it's not the right environment for people."

"If I had support at a young age it would have made a difference. I came out when I started high school and there were a lot of new people and new emotions. I was bullied for being gay for 6 years then I took a breakdown. I went to my GP and they were useless they told me they wouldn't put me on anti-depressants because I was too young. My GP told me "it seems to be the in thing for people to say they are depressed". After this I took an overdose and the nurse at the hospital referred me to CAMHS. They just asked me lots of questions but didn't give me any feedback so it didn't really help me. If my GP had said the right things and I had got talking to the right person it would have saved me going through what I went through. I eventually found out about Our Space in Derry which is for the LGBT community. I went there and they welcomed me with open arms. They had lots of programmes running with different people for all the different aspects of your experience – gay, lesbian, transgender. This person centred response was so important for me."

Theme 3: New Ways of Working

Do you agree with the ethos and direction of travel set out under this theme?

Mostly Agree

Please add any further comments you may have:

We support the need for new ways of working to ensure that services can be responsive to current needs and developments and that changes are made for the betterment of mental health services in Northern Ireland.

Do you agree with the actions and outcomes set out under this theme?

Mostly Disagree

Please add any further comments you may have:

Action 25
We are unsure of the rationale for a regional mental health service. We fear that this may be another layer of statutory services which take away from local service provision. Work to achieve better consistency across service provision should be the focus of actions rather than setting up a new regional service.

Consistency in service provision across Northern Ireland is very important. It can often be the case that services are better in bigger cities but not in more local areas which may be a particular consideration for those living in rural areas – see Section 2.2. The PPR Campaign on access to counselling services (see Section

2.11.1) points to inconsistent provision across Northern Ireland which is highly undesirable.

Action 26
This must include GPs and the points raised previously about the need for greater training of GPs in mental health issues and the need for ongoing training to be provided to GPs on these issues.

We believe that the review of the mental health workforce should include the community and voluntary sector and include training and peer support for this sector also.

Action 27
Peer Support is an important method of engaging people who are hard to reach and who prefer to engage with people they know.

Action 28
There is a need to strengthen the data available in relation to mental health particularly data disaggregated by Section 75 groups. This should include funding more studies which focus on women's health and responses to treatment to eliminate the gender bias evident in diagnosis, treatment and medical research.

Data broken down by all the equality groups is essential to an understanding of those who are experiencing mental health issues and how multiple identities can combine to make the situation even worse. It is also vital in determining where actions should be directed to effectively target mental health issues.

Women agreed that it was important that robust evidence is used as the basis for making decisions. However, they noted a trend in the use of "outcomes" in all strategies and were concerned that this is corporate speak which is designed to make people feel better but does not actually make any real difference.

Action 29
Women urged caution that this would mean putting an impressive building somewhere and thinking that is the job done. However, the women were encouraged to note that this Action did include the word "funding". This is an issue we come back to time and time again. Funding must be provided to ensure that each of these Actions are achievable.

Prioritisation

If you had to prioritise the actions set out above, which top 5 actions would you take forward (with 1 being the most important to you, and 5 being the 5th most important to you)?

This is a difficult question to answer as so much of what is included in the draft Strategy is important in effectively addressing the mental health needs of our

population. There is a danger in prioritising issues as it can give legitimacy to only taking action on certain things.

In discussions with women around prioritisation they felt that most of the Actions were important and it was very difficult to choose one over another. In addition, some the actions are about making services better and some are about creating new services so that makes it difficult to prioritise.

People often prioritise according to their own experiences and needs and that is a natural thing but this doesn't always give an overall view and this is important. Women generally felt that there was a need for much more information so that informed decisions about priorities could be made.

"I haven't heard one thing that I've thought that's not important."

The best way to make decisions around priorities is to analyse robust statistics on the issues, the urgency, geographic spread, current demands, etc. Prioritisation should be made on objective need which can only be determined with reliable and up to date data.

Many of the actions are linked to each other and this means that each action needs equal priority. Prioritising is therefore a rudimentary way of taking forward actions and therefore we are unable to give a top five list.

Instead we suggest it is better not to prioritise but instead put emphasis in the following areas:

- Making the necessary funding available to ensure that the Actions outlined in this Strategy can be effectively achieved;
- Compassionate care must be at the centre of all mental health services;
- Develop new and existing ways of working with the voluntary and community sector across all areas of mental health service provision to ensure that their work on mental health issues which is trusted within local communities is valued and invested in;
- Emphasis on early intervention and prevention to ensure that mental health issues do not get the chance to take hold and damage individuals, families and communities. This work must start from an early age in schools including teaching resilience and addressing stigma;
- Continuity of care is a hugely important for people in terms of their individual care and has benefits not only for the individual but in terms of efficiency of service provision;
- There must be no postcode lottery for access to services. Uniformity of service provision should be guaranteed no matter where you live;
- Place equal value on mental health and physical health so that mental health is not viewed as a Cinderella service;
- The Strategy will not be successful without consideration of the underlying causes of poor mental health and issues that exacerbate it including the impacts of poverty, social security and debt.

"More money is needed for mental health."

"Funding is a huge issue."

"Continuity of care is needed across all Trusts. It should not be a postcode lottery to get mental health care."

"If there is going to be a specific service for mental health it should be offered the same across all Trusts regardless of where people live."

1	
2	
3	
4	
5	

Finally, is there any one key action which you feel is missing from the draft Strategy?

We feel that there is a lack of focus on the specific mental health needs of black and ethnic minority populations and the LGBTQ+ communities who experience higher levels of mental health issues – see Section 2.4. There are particular access considerations for these groups as many face barriers to access including language difficulties, stigma and fear of coming forward due to discrimination or possible impacts on their immigration status. These marginalised groups often experience worse impacts in terms of their mental health and this bears specific reference within the Strategy.

Impact Assessments/Screenings

Do you agree with the outcome of the Impact Assessment screenings?

Disagree

Please add any further comments you may have:

We disagree with the Equality and Human Rights Impact Assessment Screening as it considers that a full Equality Impact Assessment (EQIA) is not required. It states*: "A full equality impact assessment is not required on the basis that the development of a new 10 year Mental Health Strategy does not negatively impact on any of the s75 categories."*

If all the Actions within the draft Strategy are not properly funded and implemented, then many people within Section 75 groups will be impacted by this.

Do you agree with the Equality Impact Assessment (EQIA)? **Disagree**
Please add any further comments you may have: We welcome the fact that an EQIA has been produced for the Strategy. However, we do not agree with its assessment that for most of the Section 75 groups that there will be no negative impacts. The EQIA is focusing on the provision of service not looking at objective need. While there may be no inequality in terms of service provision there is inequality in terms of need. There is inequality in terms of need in relation to gender (although it has identified a gendered need in terms of eating disorders and peri-natal mental health), disability, ethnicity and LGBTQ+ issues (see Section 2.4). A lack of data in some areas such as ethnicity and LGBTQ+ creates significant issues for determining objective need among these groups. Guidance from the Equality Commission on Effective Section 75 Equality Assessments[88] states that: *"Public authorities should ensure that screening decisions are based on relevant information, which may be qualitative and/or quantitative."* Where quantitative data in these areas has not been available for Northern Ireland more efforts should have been made to access qualitative data in these areas. This is an issue that must be urgently addressed to determine the nature and scale of the problems and where the focus of action should be.

[88] Effective Section 75 Equality Assessments: Screening and Equality Assessments, Equality Commission, July 2017
https://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/Public%20Authorities/S75Advice-ScreeningEQIA.pdf