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

Response to: Revised Service Framework for Mental Health and Wellbeing 2018-21

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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)

1.3 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

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

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 This response is informed by women's perspectives articulated in Consortium engagement events, reflecting the views of Consortium regional membership bases. The consulted cohort included a significant number of mental health service users.

2. General comments

The Women's Regional Consortium appreciates the opportunity to respond to the Department of Health's 'Revised service framework for mental health and wellbeing 2018-21'.

The Consortium works to advance the interests and enhance the wellbeing of disadvantaged, marginalised women in some of the most deprived areas of Northern Ireland. These cohorts include women in - and at heightened risk of - different kinds of poverty, including persistent in-work and intergenerational variants. Poverty can be a significant risk factor in mental ill health.[2] To compound matters, the relationship between poverty, health inequality and gender is such that poor women with mental health need may be disproportionately at risk of experiencing problems in accessing proper care and treatment in the life course:

> women's health problems and access to healthcare are affected not only by poverty, but also by gender inequality.. … the constraints of poverty and gender mean that it is poor women … who are least likely to have access to appropriate care and to seek adequate treatment.[3]

From this perspective, we welcome the consultation as affirmation of departmental intent to renew its focus on mental health sector standards with a view to enhancing service user experience in respect of care and treatment.

[2] For example, research evidences poverty as both a contributor to, and consequence of, mental ill health. See, V. Murali and F. Oyebode, 'Poverty, social inequality and mental health', Advances in Psychiatric Treatment, May 2004, 10 (3) 216-224.
[3] Z. Oxaal and S. Cook, 'Health and poverty gender analysis', University of Sussex, 1998, p.1.

Yet, in a Northern Ireland context of sustained austerity, characterised by 'systemic and long-term' under-resourcing and underprovision across different kinds of mental health need,[4] associated with 'substantial' treatment delays,[5] *we remain profoundly concerned about government capacity to deliver on this intent in substantive ways.*

As is well established, this austerity model has aggravated poverty and vulnerability while disproportionately affecting women, as compared to men, making 'many [more] women poorer and less financially autonomous'.[6] And, because poverty can be a significant risk factor in mental health,[7] this exacerbation of poverty has, in turn, been associated with (i) heightened risk to poor women's mental wellbeing and (ii) increased mental health service demand.[8] The controversy at the heart of this policymaking nexus is thus this: ongoing austerity has the potential to *at once* increase mental health need *and* innately constrain sectoral potential to meet that need.

There is a clear and compelling social justice case for policymaking in the jurisdiction to effectively and meaningfully address the complex relationship at hand between austerity, poverty, gender, mental health under-provision and risk to women's wellbeing. Participant discussion informing this paper anecdotally evidenced that case, citing endemic shortfalls in service delivery across the mental health sector at large, indicating a chronic lack of access among disadvantaged, vulnerable women to proper care and treatment, all of which was associated with either profoundly constrained mental wellbeing or the threat thereof. Accompanying cohort dissatisfaction with service levels and quality while directed, in general, at the wider mental health sector focussed, in

[4] G. Wilson et al., 'Regress? React? Resolve? An evaluation of mental health service provision in Northern Ireland', QUB: Belfast, 2015, p.2, p.v.
[5] Ibid., p.v.
[6] Fawcett Society, 'The impact of austerity on women, policy briefing', Fawcett Society: London, 2012, p.3.
[7] See, Murali and Oyebode, op. cit.
[8] See, for example, D. Gunnell, et al. 'The 2008 global financial crisis: effects on mental health and suicide', University of Bristol: Bristol, 2015; also, Liverpool Mental Health Consortium, 'The Impact of Austerity on Women's Wellbeing', LMHC: Liverpool, 2014.

particular, on hospital delivery and primary care provision at the level of general practitioner and community outreach.

The case was subsequently made for enhanced provision in the wider women's sector to address the mental health needs of vulnerable women in the most deprived districts, particularly provision under the women's centre model, which seeks to address the complex nature of women's vulnerability, including the wellbeing impact of profound disadvantage, through integrated frontline provision.

The remainder of the paper explores this dilemma further while addressing associated concerns.

3. Specific comments

3.1 Women, austerity and poverty: mental health debacle

In critically reviewing the departmental proposals, event participants universally made the case for robust policymaking to address the wider relationship between austerity, poverty, under-resourcing of mental health and women's constrained mental health and wellbeing.

Because cohorts disproportionately impacted by ongoing austerity reductions to in- and out-of-work social security income include the most vulnerable and poor,[9] its cumulative adverse impact on everyday lives has been partially characterised in terms of exacerbated vulnerability and poverty.[10] And, because poverty can be a significant factor in mental ill health,[11] this exacerbation of poverty has, in turn, been associated with diminished mental wellbeing. Within this context, it has been established that this austerity model, precisely by disproportionately impacting women adversely, as compared to men, and

[9] See, for example, C. Beatty and S. Fothergill, 'Hitting the poorest places hardest: the local and regional impact of welfare reform', Sheffield Hallam University: Sheffield, 2013. See also, J. Ginn, 'Austerity and inequality: exploring the impact of cuts in the UK by gender and age', Research on Ageing and Social Policy, 1(1), 28-53. Further see H. Aldridge and T. McInnes, 'Multiple cuts for the poorest families', Oxfam: London, 2014.

[10] Ibid. See, also, M. Aylott et al. 'An insight into the impact of the cuts on some of the most vulnerable in Camden', Young Foundation: London, 2012. See also, N. Hudson-Sharp et al.,'The impact of welfare reform and welfare-to-work programmes: an evidence review', Research Report 111, Equality and Human Rights Commission: London, 2018.

[11] See, Murali and Oyebode, op. cit.

therein aggravating the relationship between gender and poverty, has had a 'devastating' impact on women's health,[12] including their mental wellbeing.[13] Research thus suggests some kind of correlation between austerity-driven fiscal restraint, poverty, gender and mental health.[14]

Participants anecdotally evidenced this correlation. The following aspects of austerity social security reform were singled out as particularly detrimental to women's mental health and wellbeing: the two-child limit on benefits; problematic claimant navigation of the universal credit system, especially difficulties in transitioning to new benefits; delays to payments; and, punitive Personal Independence Payment assessment, depicted as 'very scary' and 'degrading'.

Research also notes the adverse impact of ongoing austerity on the funding of mental health provision in the Northern Ireland case. That impact has been characterised as 'systemic and long-term' underfunding[15] associable with problematic provision in areas such as psychological therapies, early intervention and suicide prevention.[16] The alarming nature of this reality is driven home when the scale of mental health need in these areas is considered, for example, need indicated by the jurisdiction's high suicide rate.

The question of enhanced intervention - *or lack thereof* - on this front has clear rights implications. Accordingly, the United Nations Committee on the Elimination of Discrimination Against Women has urged government to mitigate the impact of ongoing austerity on women and services delivered to women.[17] Self-evidently, the prospect of meaningful analysis of any such mitigation

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[12] L. James and J. Patiniotis, 'Women at the cutting edge: why public sector spending cuts in Liverpool are a gender equality issue', Liverpool John Moores University: Liverpool, 2013, p.12.
[13] On this, see LMHC, op. cit.
[14] Ibid.
[15] Wilson et al., op. cit., p.2, p.v.
[16] J. Thompson, 'Mental health and illness in Northern Ireland (1): overview – related strategy and reports'. [Online]. Available at: http://www.assemblyresearchmatters.org/2017/03/08/mental-health-illness-northern-ireland-1-overview-related-strategy-reports/
[17] EHRC, 'Concluding observations of the Committee on the Elimination of Discrimination against Women understanding what governments need to do to advance women's rights in Great Britain', EHRC: London, 2014. [Online]. Available at: https://nawo.org.uk/wp-content/uploads/2015/09/CEDAW-concluding-observations-EHRC-and-NAWO.pdf

across the austerity project at large would intrinsically rely on the inclusion of an explicit gender perspective underpinned by a robust, reliable and relevant gender disaggregated evidence base.

Recommendation

Government should attend to the cumulative mental health impact of ongoing austerity, pursuing improved mental health outcomes for disadvantaged women affected by the relationship between austerity, gender, poverty and constrained wellbeing.

3.2 Mental health service deficits: community provision

Participants presented the mental health controversy at hand as compounded by the withdrawal and threatened withdrawal of vital frontline mental health provision for women at the level of the community, including outreach provision for the most vulnerable and at-risk.

An appeal was subsequently made for remedial action from government to address the severe underfunding of mental health at the level of the community, particularly in the most deprived districts. It was emphasised that because such districts may be disproportionately affected by some of the key structural factors underlying poor mental health, such as unemployment, they can experience considerably higher rates of mental ill health, such as in respect of suicide and self-harm. Accordingly, this appeal was extended to include robust structural (anti-poverty) interventionism.

Participants underlined the unique positioning of community-based women's sector providers as potential collaborators in such interventionism. Recent departmentally commissioned research lends insight into what is at stake in this debate, illustrating the at-risk cumulative contribution of women centre delivery to the prevailing anti-poverty agenda developed under devolved government.[18] As noted, this delivery model seeks to address the complex nature of women's vulnerability, including the wellbeing impact of profound disadvantage, through

[18] See, Morrow Gilchrist Associates, 'Evaluation of regional support arrangements for the voluntary and community sector', Morrow Gilchrist Associates: Belfast, 2015.

integrated frontline provision. This includes remedial work on resilience-building intended to address complex needs around the mental wellbeing impact of constrained processes of self-development and self-actualisation. The anti-poverty impact of this work is characterised in terms of remedial outcomes across different kinds of disadvantage, including intergenerational variants and that experienced by ethnic minorities, as well as different kinds of poverty.[19] More precisely, that variegated impact is presented as entailing the delivery of a plethora of positive developmental outcomes at the level of the individual, the wider family, the community and society at large, from enhanced individual wellbeing, agency and life chances through to improved community cohesion and economic capability.[20]

Discussants called for government to commit not only to sustaining such provision but also to strengthening and augmenting it, complemented by improved signposting to same across the mental health sector at large. Within this context, the point was explicitly made that public funders should take account of the profiles of smaller organisations in the funding process itself. Limited resourcing and capacity can mean smaller organisations are at a distinct disadvantage in processes where application completion can be especially labour intensive, such as tendering processes. From this perspective, the case was made for alternative – more appropriate and sustained – kinds of funding to promote continuity of vital delivery on chronic vulnerability within such organisations. Particular emphasis was placed on the merit of grant aid funding on three-year cycles.

In addition, the case was made for early intervention - at pre-school and school age - to address key factors underlying mental health inequalities between the most and least deprived areas, and thus help disrupt the cycle of intergenerational mental ill health in low-income households.

[19] Ibid.
[20] Ibid.

Recommendation

In pursuit of improved mental health outcomes for disadvantaged women, government should seek to properly address underprovision of mental health at the level of the community, giving particular attention to the social justice case for enhancing its support for vital frontline provision in the women's centre delivery model under grant aiding. This should include a commitment to enhanced resourcing of early intervention to help disrupt the cycle of intergenerational mental ill health in low-income households.

3.3 Disadvantaged women's mental health: legacy of the conflict and gendered violence

Research suggests how women's experience of mental ill health in Northern Ireland can correlate to the legacy of the conflict. Disadvantaged individuals in the jurisdiction are in general 'much more likely' to cite an impact of the conflict on their everyday lives,[21] and the 'burden' of conflict-associated anxiety and depression tends to fall disproportionately on women.[22] Some kind of correlation is therein suggested between disadvantage, gender, conflict and mental ill health.[23]

Participants reported that, in many cases, the mental health impact of the conflict on women was complicated by the experience of gendered violence. By engendering fear and intimidation at the level of the individual, the family, the community and society at large, the conflict has been identified as having 'masked the perpetration of domestic and sexual violence', resulting in the 'silencing of women' as victims of such violence and the denial of access to

[21] C. C. Kelleher, 'Mental health and "the Troubles" in Northern Ireland: implications of civil unrest for health and wellbeing', Journal of Epidemiology and Community Health 2003; 57:474-475, p.474. See also, C. C. Kelleher, D. O'Reilly and M. Stevenson, 'Mental health in Northern Ireland: have 'the Troubles' made it worse?' Journal of Epidemiology and Community Health, 2003; 57: 488-492.

[22] M. Tomlinson, 'The trouble with suicide mental health, suicide and the Northern Ireland conflict: a review of the evidence', DHSSPSNI: Belfast, 2007.

[23] See, for example, Commission for Victims and Survivors, 'Towards a better future: the trans-generational impact of the Troubles on mental health', Commission for Victims and Survivors: Belfast, 2015.

justice.[24] Research suggests how policymaking might take better account of the complexity of implicated gendered issues in this debate.[25]

The point here is this: by imposing 'substantial' treatment delays for conflict-related disorders,[26] the austerity-driven underfunding at hand obviously risks aggravating this correlation, further threatening the mental wellbeing of disadvantaged women while further heightening the risk of aggravated health inequality.

Recommendation

In pursuit of improved mental health outcomes for disadvantaged women, government should take more seriously the cumulative mental health impact of the legacy of the conflict and its association with gender violence, ringfencing provision in this area from any further fiscal cuts under extended austerity.

3.4 Rural picture: infrastructural shortfalls and isolation

This picture of constrained mental wellbeing and risk thereof is further complicated by consideration of rural-specific contextual factors. This includes the cumulative adverse impact on everyday lives of the enduring legacy of infrastructural underinvestment in rural, and subsequent rural/urban socio-economic indicator differentials,[27] which research associates with aggravated social isolation and disconnectedness.[28] For example, links between social isolation and transport infrastructural shortfalls. The point here is this: social isolation remains a key risk factor in mental ill health[29] and so, on this view, infrastructural shortfalls appear in some way associable with mental health risk.

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[24] NIWEP, 'An inquiry into the position of women in Northern Ireland since the peace agreement summary report', NIWEP, Belfast, 2015.
[25] Ibid. See also, M. McWilliams and F. Ní Aoláin, 'Advancing gender equality in Northern Ireland: addressing domestic violence and human rights protections for women', KESS, Ulster University, Belfast, 2014.
[26] Wilson et al., p.27.
[27] For example, as the executive's own research puts it in respect of public sector funding differentials to the wider women's sector: 'compared with levels of government funding to women's groups in urban areas, there was a relatively low level of government funding to rural women's groups'. DSD/OFMDFM, 'Review of government funding for women's groups and organisations', DSD/OFMDFM: Belfast, 2012, p.13.
[28] See, for example, M. Allen, 'Rural isolation, poverty and rural community/farmer wellbeing - scoping paper', Research and Information Service Briefing Paper, NIA: Belfast, 2014.
[29] Thompson, op. cit.

Recommendation

In pursuit of improved mental health outcomes for disadvantaged rural women, government should take more seriously the relationship between infrastructural inadequacy, social isolation and risk to mental wellbeing.

3.5 Treatment and care: systemic failure

Participants reported significant widespread problems with care and treatment in respect of a plethora of mental health conditions, including anxiety, different kinds of depression (pre-natal, post-natal and manic), obsessive compulsive disorder, post-traumatic stress disorder and suicidal tendency. This reported dilemma was summarised by one participant this: 'there is no proper care, no proper support'.

The cited problems are set out in the table below.

Treatment and Care Problems Identified by Participants

- Substantive treatment delays and postponement, including waiting lists and waiting times across different interfaces, particularly hospital and general practitioner services
- Inadequate opening hours of general practitioner surgeries
- Prohibitive travel costs as a significant barrier to treatment access
- Lack of proper care, including continuity of care, particularly in respect of more complex needs
- Practitioner inattention to the relationship between physical and mental heath
- Practitioner neglect and mistreatment
- Lack of practitioner professionalism
- Misdiagnosis and over-diagnosis
- Deficits in practitioner empathy and respect
- Lack of proper communication and information from providers
- Overmedication and inappropriate medication
- Unfulfilled duty of care
- Overemphasis on 'trial and error' treatment methodology
- Misuse of zero tolerance policy to suppress valid service user critique at different practitioner interfaces (general practitioner surgeries and elsewhere)
- Prohibitively restrictive practitioner face to face time
- Reluctance of mothers to seek treatment fearing involvement of social services and potential removal of children
- Unfair regional variation in care and treatment, i.e. 'postcode lottery'

- Adverse service implications of prohibitive red tape
- Underprovision of suicide awareness and prevention intervention
- Lack of specialised services
- Lack of properly integrated, coordinated service delivery tailored to individual need

It was concluded that these problems were indicative of 'systemic failure' attributable to austerity associated systemic under-resourcing of mental health, and that what was consequently required to remedially address this debacle was to, as one participant put it, 'change the whole system root and branch'.

Recommendation

Government should undertake to capture and address the *systemic* impact of longstanding systemic underfunding on mental health treatment and care, ringfencing mental health at large from any further cuts under extended austerity.

3.6 Mental health debacle: redirecting of MLA salary fund

Participants expressed profound frustration at the absence of a devolved government to strategise on the reported mental health debacle. This introduces the notion of political accountability into this debate. From a social justice perspective, holding government to account on this front can raise questions of, inter alia, inclusion, equality, recognition and rights fulfilment.

That said, a broad consensus emerged according to which the return to devolved government *would make no substantive difference to the status quo as long as austerity persisted*. This consensus was accompanied by strong objections to the continued payment of salaries to members of the local assembly, and a call for the salary fund to be redirected to mental health as a matter of some urgency.

Recommendation

It is recommended that government reconsider the continued payment of salaries to members of the local assembly in the absence of a meaningful

commitment from them to form an executive, taking account of how these monies might be redirected to address urgent questions of mental health need.

3.7 Gaps in gender disaggregated data: addressing intersectionality

In addition to proper resourcing, realisation of effective and meaningful policymaking on the reported mental health dilemma at hand would fundamentally rely on the availability of a robust gender disaggregated data evidence base that accurately captured the implicated intersectionality in this debate, for example, interaction between gender, mental health and ethnic minority status.

Lamentably, however, such an evidence base is conspicuously absent given prevailing gaps in government information gathering and data collation (both quantitative and qualitative). For example, these gaps are such that it has been noted that 'little, if anything is known about ethnic minorities' outcomes in relation to health'.[30]

Recommendation

In pursuit of improved mental health outcomes for disadvantaged women, it is recommended that government attend to such prevailing gaps in gender disaggregated data as might undermine meaningful policymaking across the intervention prioritisation areas identified in this paper.

4. Conclusion

This paper has set out a social justice case for policymakers to properly capture and address the complexity of the relationship between austerity, gender, poverty and mental health in the Northern Ireland case. For obvious reasons, this advocated policy manoeuvre has been defined in terms of properly resourced and properly informed intervention. As already stated, we, of course, recognise that the notion of adequate resourcing remains innately inconsistent with the structural status quo of extended austerity. Nevertheless, this debate raises urgent questions of rights and equality that it behoves policymakers to take seriously.

[30] Ibid., p.51.

The United Kingdom's impending exit from the European Union (Brexit) further complicates this debate. Research suggests Brexit could significantly aggravate pre-existing inequality and vulnerability, disproportionately impacting women.[31] A robust gender perspective on the wider debate remains paramount.

[31] This projection is based on the gendered nature of recent economic shocks, particularly the United Kingdom recession-austerity model that followed the 2008 global financial crisis. The idea is that any post-Brexit economic downturn 'would bear more costs on women than men, as they are more frequently situated in more vulnerable working and social positions'. A. Jenichen, 'What will Brexit mean for gender equality in the UK?' Aston University: Birmingham, 2016. [Online]. Available at: www.aston.ac.uk/EasySiteWeb/GatewayLink.aspx?alId=285498. See also, I. Begg and F. Mushövel, 'The economic impact of Brexit: jobs, growth and the public finances', London School of Economics: London, 2016. [Online]. Available at: https://www.lse.ac.uk/europeanInstitute/LSE-Commission/Hearing-11---The-impact-of-Brexit-on-jobs-and-economic-growth-sumary.pdf. See also, A. Armstrong et al. 'The EU referendum and fiscal impact on low-income households', NIESR, London: 2016