The Experiences of **Women Engaging with Mental Health Services**

HSE Mental Health Engagement & Recovery

Mental Health Reform

An Roinn Sláinte
Department of Health

Glossary

MHER	Office of Mental Health Engagement and Recovery
MHR	Mental Health Reform
HSE	Health Service Executive
GP	General Practitioner
PTSD	Post Traumatic Stress Disorder
ADHD	Attention Deficit Hyperactivity Disorder
OCD	Obsessive Compulsive Disorder
WRAP	Wellness Recovery Action Plan
NPIRS	National Psychiatric Inpatient Reporting System

Introduction

A Women's Health Taskforce was established by the Department of Health in 2019 to improve women's health outcomes and experiences of healthcare. In 2021, a dedicated multi-annual €5 million Women's Health Fund was established to implement a programme of actions arising from the work of the Taskforce with an additional €5 million committed in 2022 to fund innovative new approaches to women's health services nationwide.

The need to protect mental health and to address gaps in mental health services was a priority theme identified in the radical listening exercise, 2021, commissioned by the Women's Health Taskforce, to improve women's mental health outcomes and experiences of healthcare.

In 2022, the Offices of Mental Health Engagement and Recovery (MHER) along with their support partner Mental Health Reform (MHR) secured funding from the Women's Health Fund to host two consultations with women about their experiences of mental health services. Consultations were also undertaken to look at the impact of perimenopause and menopause on their mental health.

This report focuses on the outcomes of the consultation with women on their experiences of Mental Health Services. **The target group is women using mental health services in community and inpatient settings.**

The National Office of Mental Health Engagement and Recovery is part of the Health Service Executive's (HSE) Mental Health Services. The purpose of the MHER Office is to drive and support the development of core service improvement in mental health services.

Mental Health Engagement itself is a two-fold process by which

1. **Service users, family members, and carers engage with their mental health service providers on their recovery journey and beyond.**
2. **It also relates to integrating service user, family members, and carer perspectives in the design and development of services.**

Engagement travels across a continuum as outlined below:

Peer-led: Individuals, groups or communities lead their own decisions, solutions and activities, and may collaborate or seek support in doing so.

Co-produce: Implement, deliver and evaluate supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship.

Co-design: Identify and create a plan, initiative or service, that meets the needs, expectations and requirements of all those who participate in, and are affected by the plan.

Involve: Work with people throughout a process to ensure their concerns and opinions are included in the decision making process and in the development of alternative solutions.

Consult: Obtain feedback on plans, proposals and processes that may influence current and future decisions and assist with the development of alternative solutions.

Educate: Provide opportunities to learn more about plans, proposals and processes to assist people to understand problems, alternatives and solutions.

Inform: Provide information to people and let them know what has been decided and what is going to happen.

For this project, our engagement approach was consultation; we consulted with women to gather their feedback on their experiences of Mental Health Services and the support they have encountered.

Our partner Mental Health Reform is Ireland's leading national coalition on mental health. Their vision is of an Ireland where everyone can access the support they need in their community, to achieve their best possible mental health. In line with this vision, they drive the progressive reform of mental health services and support, through coordination and policy development, research and innovation, accountability, and collective advocacy. MHR provides a unified voice to Government, its agencies, the Oireachtas, and the general public on mental health issues.

MHER and MHR, came together on this project due to a mutual priority of listening to the experiences of people with lived experience in their recovery journeys.

We would like to acknowledge the generous support of our MHER and MHR colleagues, and our community colleagues, in particular, Women's Mental Health Network, National Women's Council Ireland, Samaritans Ireland, Aware and Shine without whom this project would not have been successful.

Report compiled for MHER by Orla Barry, an independent consultant. Orla previously worked in leadership roles in Mental Health Ireland, Mental Health Reform and mental health services in the Eastern healthboard.

Context Setting

The report documents the experiences of women accessing mental health services in Ireland gathered through consultation and survey.

In total 287 women describe their experiences engaging with mental health and primary care services; private hospital and community-based services and local community, voluntary services and peer led projects.

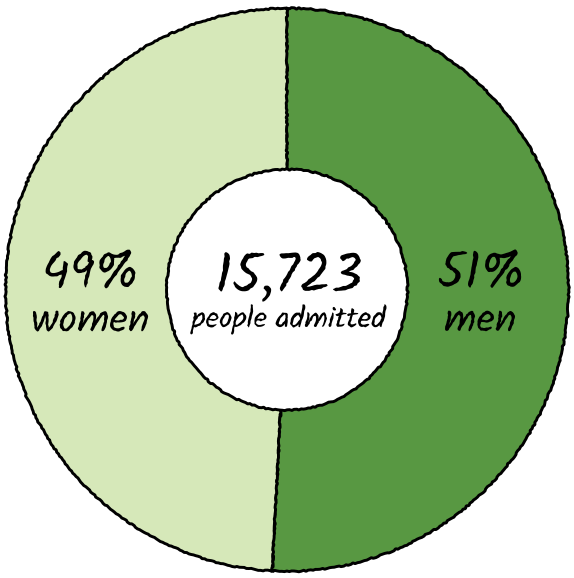
In the HSE, as of 2021, there are 112 adult Community Mental Health Teams nationwide each catering for a catchment area of about 50,000 population within the 9 HSE Community Healthcare Organisations.

The inpatient services include:

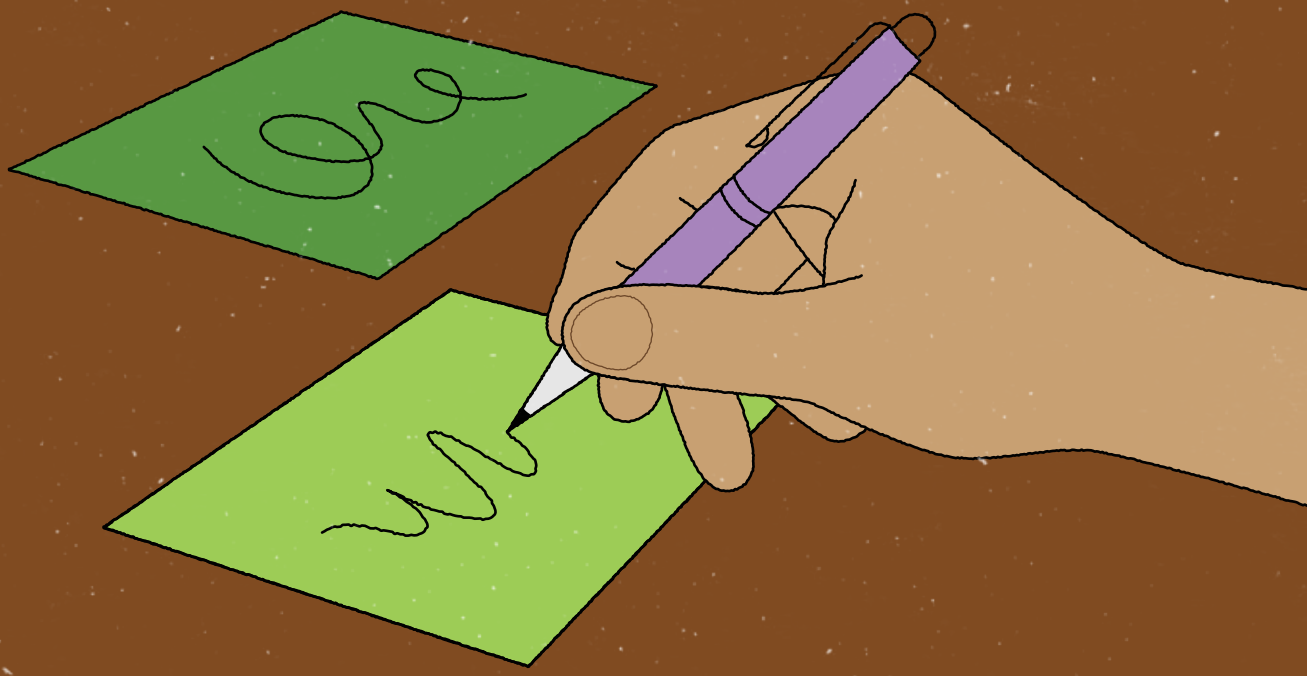
- **23** **General hospital mental health units**
- **26** **Mental health hospitals/ continuing care units** run by the HSE
- **7** **Independent/ private and private charitable centres**

Many local community, voluntary services and peer led projects are grant funded by the HSE.

As reported in the NPIRS Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2021[1], **15,723 people** were admitted to Irish mental health units and hospitals in 2021. Women were **51%** of all admissions and had a slightly higher rate of admission at 331.3 per 100,000 compared to 329.0 for men.



1 https://www.hrb.ie › fileadmin › NPIRS_Report_2021



Participants and Approach

Participants for this consultation were recruited via a public social media campaign on both Twitter and LinkedIn as well as by invitation shared with MHER and MHR networks.

In Autumn 2022, 25 women participated in two in-person Recovery Cafés and 262 women participated in an online consultation.

The consultations used the Scottish Recovery Network model of a Recovery Conversation Café[2]. The 25 women who participated had experience of both community and inpatient mental health services.

At both in-person consultations participants were reminded of supports available to them; **Samaritans** volunteers were present and safety was paramount for the people taking part.

As part of this work, an online survey was launched in November 2022. A total of **262 women** aged 18 or older, who currently or previously accessed formal support for their mental health, completed the survey. Of these, 69 respondents accessed HSE and private in-patient services; 30 accessed HSE inpatient and community services only, 18 accessed private inpatient services only and 20 accessed a combination of both. Private services refer to independent hospitals and clinics and private therapists or counsellors. All private services charge for their service and may be for-profit or non-profit organisations.

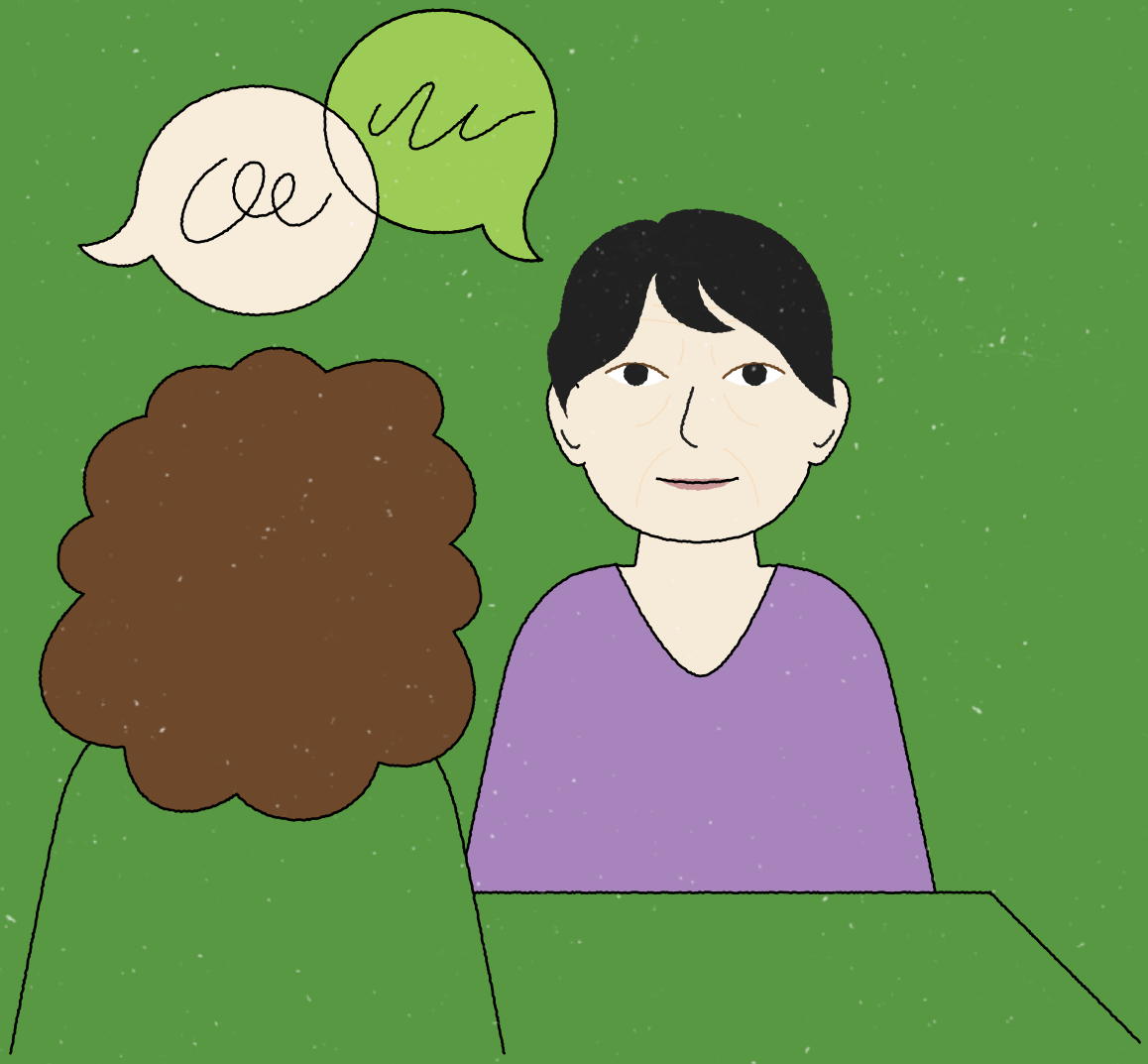
The survey group had a greater proportion of young women aged 18-35 than the Recovery Cafés.

The Recovery Café is appreciative in style asking participants to discuss what's working, what would make it a better experience for you and how could services and supports be improved? The survey follows the same thread of questioning, eliciting an individual perspective.

1. **As a woman, what is your experience finding support for your mental health?**
2. **What's your experience of mental health services; what works well for you and what would make it a better experience?**
3. **How could women be better supported by the mental health services? What would change look like? How could your voice be included?**

This report documents common themes and specific issues in relation to women's experiences of mental health services. The report groups these perspectives into themes and presents them here as they were received, without bias or influence in **The Conversation**, What Women Said, What Women Want. The report considers the women's views on what services and supports could respond best to their needs in the final **Reflection**.

2 https://www.scottishrecovery.net/resources/recovery-conversation-cafe-toolkit/

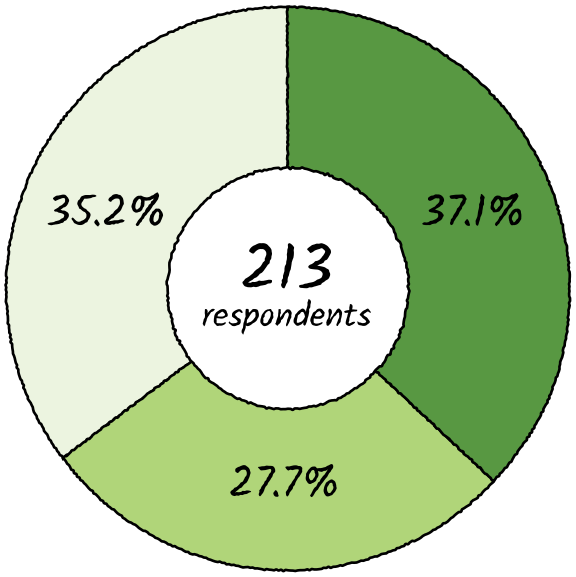


The Conversation

Do you feel that being a woman has impacted your experience of mental health services?

Participants in all three Recovery Cafés agreed that being a woman did not impact on accessing mental health services. The general consensus is that both men and women have the same benefit or difficulty in accessing services. In later discussions issues arose about menopause, postnatal support, childcare, medication and safety that explored women's experiences.

Survey participants responded as follows; **37.1%** agreed that being a woman has impacted their experience of mental health or mental health services; **27.7%** disagreed and **35.2%** responded 'don't know'.



A concluding comment reflects the discussion on women's mental health needs:

"Women have to justify themselves so much when it comes to mental health needs especially when pregnancy, birth or menopause cause or contribute to the problems."

WHAT WOMEN SAID

All the women accessed mental health services and support in their community and a minority accessed inpatient services. Reflecting this experience, women's views on accessing services are presented in two sections; **Women Accessing Mental Health Support in the Community** and **Women Accessing Inpatient Services**.

Women Accessing Mental Health Services and Support in the Community

The café conversation participants all accessed community mental health services including Community Mental Health Teams (CMHT), peer support projects and groups and community organisations including Grow and Shine.

Of the 132 women surveyed, who had no experience of inpatient services, 60 women accessed Community Mental Health Teams.

The café conversations and the survey responses show an overall pattern of women having difficulty accessing services. Once in the system the consistency of the relationship with mental health professionals and experience of respect greatly influences women's satisfaction with services.

Waiting lists for Primary Care and HSE Mental Health Services impacts women's choice and many described seeking private psychotherapy or private mental health consultation because they were unable to access a public service. Coupled with limited access, a perception of the HSE services *not being good* emerged. **In contrast, the majority of women, engaged with HSE services describe a satisfactory experience with the Community Mental Health Teams.**

A trusted doctor, community supports, counselling and psychotherapy, family support, accessing holistic therapies and engagement with Community Mental Health Teams and private Mental Health Services worked well for women.

Over reliance on medication in some contexts and the impact of women's menstrual cycle on mental health were raised as concerns.

Medical Consultation

A GP was described as *'the first port of call'* and a consistent, supportive relationship with a GP was described as helpful by many women.

— Great male GP, helped that I consistently saw a person who knew me.

— My GP is good and understanding.

A reliance on medication was queried. The need for more discussion and choice about treatment options was raised.

— There's too much emphasis on medication and then you need more medication for the side effects.

— They don't tell you about the side effects or ask about the interactions with other medications such as blood pressure meds.

— Being prescribed antidepressants by a psychiatrist after years of being prescribed by GPs who only upped the dosage. This literally saved my life.

— I couldn't begin the conversation. A male GP and a male psychiatrist made no connection between mental health and menopause and my menstrual cycle.

— When going through menopause I spoke to the GP. I knew something was wrong. I was able to work out the menopause was the issue when attending Grow groups.

— GP's should not be allowed to prescribe antidepressants without a blood test.

– Menopause affected my mental health really badly.

Community Supports

Not-for-profit organisations provide a range of education and support services. Projects such as Involvement Centres, Recovery Colleges and Recovery Education Services nationally are led by, or in partnership with, people with lived experience of mental health difficulties. Many peer groups such as Cosán in Galway have been set up to support people with mental health difficulties in their local communities.

Of the women surveyed **25.5%** were supported by their peers; **10.2%** accessed a Community Peer Support Centre; **8.8%** attended a Recovery College and **28.8%** were supported by a voluntary organisation or charity.

Access to Recovery Colleges, peer support groups and community organisations was identified as **very important** for the women participating in the café conversations.

— Personal development – the Involvement Centre in Kilkenny is brilliant!

— I joined the committee of a family peer support group, which helped me feel useful. Peer groups are really helpful because you're in a room with people who are going through the same thing, even more helpful than talking to the expert clinicians.

— I was on the Eden program (Suicide or Survive). I was with like-minded people. It helped me a lot.

— Best thing I have ever done is started attending ACOA 12 Step Fellowship and working through their trauma workbooks with fellow travellers. Years of counselling never hit the nail on the head – my chronic mental health issues are due to complex trauma growing up in a dysfunctional family.

— Grow, Mental Health Ireland, Family Carers Ireland counselling, Solas walking group – those who have experienced challenges/ struggles you face are always much more in tune with the needs of others.

Counselling and Psychotherapy

Women talked about accessing low cost therapy, counselling in primary care, private psychotherapists and counsellors and not for profit organisations including Pieta and MyMind. However, cost and availability were raised as challenges and a number of women describe paying for private counselling as the waiting lists for free counselling were too long. There was a strong call for more psychologists in the HSE Community Mental Health Services.

— I found counselling really helped.

— My private counsellor and being able to access appointments via zoom, however it is a huge expense and my counsellor is now increasing my fees so I have to stop going.

— Pieta house was the only place I feel really helped me.

Support for mothers and family came up in a number of ways. The benefit of home based team support for women and their families was highlighted as was a need for perinatal and postnatal mental health support.

— I had no help after having my son. When pregnant on my second I was offered support in the hospital by a special midwife. She followed on my care after my daughter was born.

Sometimes family relationships may be unsupportive.

— Families don't work as support for everyone. It's doubly hard if it's not a good family support.

Women described their experiences engaging with **Community Mental Health Teams**.

— *The mental health nurse who called me at the weekend to make sure I was okay saved me. She knew the medication I needed straight away.*

— Work with an OT long-term. Attending the day hospital long term. Regular appointments with a Key Mental Health Nurse. Regular appointments with the consultant psychiatrist. No mention of discharge from the services because it triggers my fear of abandonment. Regular appointments with my GP.

— *Services which are very quick to access after initial referral. Access to community services in between psychiatric appointments was excellent. I can honestly say they saved my life, they were on the phone within hours and worked with me at my pace. I was given the option to go to hospital but preferred to stay at home, they phoned every day to ensure I was okay. I can't thank them enough.*

— The Public Health Nurse and my GP had been wonderful and very supportive. The Community Mental Health team less so. They seem completely overstretched and are pushy when it comes to medicating for depression.

— Experience moving to (a rural area) in the last year has been positive, fast referral from GP to Community Mental Health Services and review of medication conducted. Follow-up

appointment within a few weeks rather than months waiting.

— Medical attention of crisis points along with family support. However I've had to learn to advocate for myself and this is not always easy when experiencing depression.

Health insurance may facilitate women's access to **private mental health services** and many women pay directly for private therapy or consultations. There is a perception that public health services are difficult to access or of poor quality.

— I'm lucky I can pay for private mental health services. However, regardless of this, I have been put on weeks long waiting list to see a psychiatrist, even during a time of personal crisis. Overall, my experience of private mental health services has been good. I have not availed of public mental health services and would prefer not to, as the waiting list is far too long, and I've heard of too many bad experiences from friends who have used them.

— Support from community, voluntary, private supports. HSE service only step in when things get to crisis point. I've been lucky that I've been able to afford to get support privately but even at that no one can afford to attend a private counsellor for €70 a week.

— Privately and GP, HSE are absolutely shocking to try get help from!

— Private psychiatric care really helped me. Public services are impossible to get access to.

Many women described a **financial strain** paying professional fees.

— I paid for a private psychologist because waiting time was too long and as I don't get paid being out sick. I needed to be helped ASAP, I'm now in thousands of Euro in debt, earning minimum wage and trying to keep my mental health in a positive place.

— Private, we had to forego every day essentials to pay for private therapists that were required. HSE mental health is a disaster.

Women describe the benefit of seeking expertise for OCD, ADHD and Eating Disorders through **private services**.

— Psychiatrist who gave a proper diagnosis in a private hospital and having other professional friends who suggested a good private CBT therapist. GP misdiagnosed postpartum depression when it was OCD which set me back and the PHN only screens for postpartum depression when if she had asked about obsessive thoughts I would have realised it was OCD.

— Counselling hugely helpful. Holistic eating disorder treatment at (a private therapy centre) saved my life.

— I went private for psychotherapy and it went well for a time but I left. The HSE services are very limited. For example, ADHD..... The issue is that there are no adult ADHD facilities in the HSE, so we are forced to go privately in Ireland or abroad.

One woman found alternative **holistic practitioners** helpful.

— Finding someone who uses alternative methods including energy work.

— I'm lucky I can pay for private mental health services. However, regardless of this, I have been put on weeks long waiting list to see a psychiatrist, even during a time of personal crisis.

And what would make it a better experience?

Women said that better access to services, more respect and listening, a consistent doctor, less reliance on medication, a mind body focus, support for families and greater access to free or affordable therapy would improve their experience of mental health services.

Better access includes access to Primary Care and Community Mental Health Teams with regular appointments, waiting lists reduced, **emergency support separate from A&E and services close to home**. The transition from CAMHS to adult services at 18 years was also named.

— The wait time for HSE services was just too long.

Respect and listening, compassion and flexibility, more empathy and a non-judgmental approach would improve women's experience engaging with health professionals.

— A willingness from medical practitioners to listen and see the whole person.

A consistent doctor and a relationship with one consultant would improve women's experience.

— Being treated by one psychiatrist only would have been a great help. Having to explain everything to a new doctor every few weeks is exhausting and means your medication gets changed constantly based on what the current doctor deems best. There is no continuity of care and you can't build any sort of trusting relationship with your doctor so you become afraid to be completely honest for fear of being sectioned because your latest doctor might see a risk level is higher than a previous doctor.

Less reliance on medication by both GPs and psychiatrists in treating mental health difficulties and **more access to psychology and other approaches** would improve women's experience.

— Emphasis on a holistic model rather than a model of medication as first choice.

Greater awareness amongst doctors and other professionals of the **impact of women's hormones on mental health** particularly in menopause.

— I don't think being a woman is taken into account. Your body may react differently to medications.

Greater support for families and the benefits of home based treatment.

— The support of a home-based team for 13 weeks worked. It offered the family support as well.

Easier access to affordable or free counselling and psychotherapy would improve women's experience.

— Free counselling that is easily accessible without a 10 year waiting list or having to meet the criteria. If people ask for help it is not for a day out it is because we need it, having a medical model in Ireland is not the answer.

Women identified the need for better information and education on eating disorders, trauma informed practice and awareness of neurodiversity for consumers and staff. Availability of childcare, increased community supports, more pregnancy and postnatal supports and a more holistic approach would also improve women's experience of mental health services.

Women Accessing Inpatient Services said

Many of the women in Café conversations had been inpatients in mental health units and hospitals and a total of 69 women, who responded to the survey, accessed inpatient services, 19 of whom accessed private services only and 20 women accessed a mix of HSE and private services.

Many of the women are satisfactorily supported by Community Mental Health Teams and outpatient services. Reflections on inpatient experiences are both challenging and constructive.

— For some people it works well for some people not. Two sides of a coin. A dichotomy of experience.

Accessing Support

Dissatisfaction with A & E admission, stigma and poor quality GP support influenced decisions to access private inpatient care.

— I had Postnatal Depression and went to a female GP, who was very empathetic. She encouraged a holistic approach including walking etc. It worked well for me. On the second occasion, a new male GP prescribed medication only (valium) and kept increasing the dose because it wasn't working. I became suicidal, had panic attacks. The local Mental Health Service was not helpful for me as doctors were changing rapidly due to a retirement. I was repeatedly starting from scratch. I went to a private Mental Health hospital.

— I didn't want to find support, didn't want to admit it, kept it a secret. It was way down the track before I looked for support. Nobody told me you can recover, but you do need support. I was a mother, a multi-tasking parent. I hid, that was easier than asking for help. I was afraid my kids would be taken off me.

Many women described admission to hospital and crisis support as a difficult time.

— I had a crisis admission. It was difficult trying to get into hospital. If you need admission, it's very difficult.

— You should present to the unit and not wait in A&E all that time. I left and got arrested by Gardaí and got let go again over three days then admitted. Then I was sectioned under the act.

> *– Admissions are traumatic, you have to tell them everything. If you need admission it's very difficult.*

— When I was an in-patient I wanted to be an out-patient. I was scared, it was bewildering to me. They took my mobile apart and it kept happening. An invasion of privacy.

— Rule changes re mobile phones – it would be helpful to find a middle ground.

Communication

It was suggested that **better communication** would help greatly. An example of a video made by one service explaining the inpatient services was described as ***very powerful***.

— Information before coming in so there are no surprises e.g. your things will be taken off you; who will admit you; how you will be admitted.

— See the hidden system – how it's supposed to work.

A communication gap was described between the inpatient system and the community. The medical and nursing staff do not seem to be aware of services and resources in the community.

— Some OTs (in the unit) are aware of the community and the activities. The nurses and medical staff don't know what's in the community.

— The team had never heard of the Recovery College.

Dignity and Respect

Balancing risk management and personal dignity can be challenging. An example was given of a newly designed inpatient unit where there are no doors in the bathrooms or toilets.

— Imagine no doors on a bathroom, toilet and shower, degrading. Open the bedroom door and see straight into the toilet.

One ward is a mixed ward, which impacted one woman's feeling of privacy.

— Stressful. Should have men and women completely separate.

The women consider this design should not have been approved and call for the **inclusion of service users in future service design.**

— Design in an appropriate way. Coproduce and codesign with people who understand services.

Note taking was commented on in conversations and in the survey.

— Negatives are always put in the notes, positives are not included.

— On my notes – well dressed, not dishevelled. Is that how I can hide in the system and not get help?

— If you're concerned staff are only getting one side of the story, staff Peer Support Workers can put the person's view in the notes.

More Peer Support or Key Workers would help. The Key Nurse system in one HSE unit was described as helpful, having a designated nurse each shift gives continuity and improves relationships.

The right to express feelings and emotions arose in conversation.

— A nurse shined the torch on my eyes. Your sleep is broken. You're not allowed to be angry.

— The solution to anger is to medicate.

— We have a right to be angry and be heard. It's normal. Girls not allowed to be angry boys can't cry. Normal emotion seen as symptomatic.

— In the unit I started to cry, a service user kicked me under the table and said "don't be crying or you won't get out of here".

A suggestion is to ***have someone on the team to tease things out,*** to respect women's emotions. The TIDAL[3] and Safe Word[4] models were recommended.

The facilities in one HSE unit were praised; a new gym, arts and crafts, self-help groups, music sessions, yoga and meditation, and walks around the lake were available. The food was described as *exceptional*.

Facilities in an independent private hospital were also praised.

— Attention and activity from OT, Social Care etc. is important to feel like a person, not a number. I still use what I learned in hospital. The WRAP programme was very good – very practical and you owned it yourself.

One conversation concluded with the women expressing hope for mutual respect and to work in partnership.

— They don't want to see us unwell, they want to see us get better. Need to change the mindset from a medicalised approach.

One woman described a seamless transition from hospital supported by the **Community Mental Health Team.**

— **I found the mental health service is okay after the admission.** My Community Mental Health Nurse gave me a depot (injection) once a month. I catch up with him – he's connected to the team (CMHT). Meds changed at the next Out Patient appointment (he tells them what I need). I have helpful discussions with him on how I'm getting on. As a woman I wouldn't be discussing women's issues with him – periods/menopause. It would be a different relationship if it was a women, however he's good. He sees more practical things I need done.

A consistent relationship with a psychiatrist can ensure continuity of care.

— I was home 2 days later – I was surprised it was so fast. I had lots of support from family. Continuity of care is a big issue. Every psychiatrist has a different angle. Medication focused or Recovery focused. I'm very fortunate I have the same psychiatrist for years. I see the psychiatrist every three months.

3 The **Tidal Model** emphasises helping people reclaim the ***personal story*** of mental distress, by recovering their voice. By using their own language, metaphors and personal stories people begin to reclaim the meaning of their personal experiences. https://www.tidal-model.com/

4 https://www.safewards.net/model-diagram

— I had good experience of Mental Health Services because I had private health insurance. I'm 20 years linked to a private hospital and I am well. If you haven't got private health insurance in Ireland though you're in trouble.

— The greatest issue is that there is no local follow-up care from the private hospital if you are not Dublin-based. I trudged through, not sure everyone can. Information on support is really hard to find especially in rural areas. Some nurses answered calls from me after discharge which helped. I emailed the HSE for links for support but never heard.

The absence of a consistent relationship with a consultant psychiatrist was a common theme. Doctors changing and a reliance on junior doctors on rotation, causes difficulties for women.

— It took me more than two years to actually meet the consultant psychiatrist who is treating me. It was always a junior doctor.

— Continuity of care – you have different doctors in public system each visit. Very little in patient rights.

— Lack of consistency in medical staff. Wider options of support at different times through the week.

— Not having to re-tell my story, symptoms, issues every single time I go in for a renewed prescription would make a difference too.

Many women described the importance of **peer support**.

— **There's plenty of support out there but you have to find it**, Grow etc. I live in a mental health bubble; find friends through mental health. It's not good sometimes but also very good. It's very difficult to find support in the mental health service. As a woman there is no difference finding supports. Grow etc. are not for a crisis, they're for peer support. If you need admission it's very difficult.

And what would make it a better experience?

The same themes identified for women accessing community services are raised by women accessing inpatient services: better access to services, more respect and listening, a consistent doctor, less reliance on medication, a mind body focus, support for families, and access to free or affordable therapy would improve their experience of mental health services.

Dignity and Respect

Specific to the inpatient experience the call for **dignity and respect** and behaving with **kindness and understanding** reflect women's inpatient experience.

— Trust and respect should be key in care and that starts with the first encounter – often I was treated like I've done something wrong just because I was unwell.

— Nursing staff in the inpatient psych ward were dismissive and disrespectful to all patients and that was quite upsetting.

— So many things, I feel as an inpatient I could've been treated with much more dignity than I was on several occasions. I would have appreciated much better communication from my psychiatrist and team at times. I would have liked for my data to have been better protected.

— More understand you are more than just a number… also discussing your case in front of you like you're not there is very unprofessional.

Many women called for **greater kindness and understanding** from professionals.

— If psychiatrists were kinder and more understanding. If they tried to help me understand my experience of psychosis by explaining it to me and offering advice about recovery that wasn't just medication. If there was a psychiatrist at outpatient appointments every couple of months.

— **More than anything more kindness and understanding. It's really hard to speak when you're in a very bad place in your mind.** A lot more support and help around self-harm and suicidal thoughts.

Feeling safe

Feeling unsafe was raised by a number of women with inpatient experience. Mixed wards and the close proximity of others who themselves may be unwell was a common concern.

— Being valued enough to be protected from [people] encroaching into spaces where I am vulnerable.

— My experience as a public inpatient (two admissions) was very difficult. The staff were good and did their best for the most part but I was frightened in there at times. It wasn't equipped for somebody who is suicidal but not experiencing psychosis or similar issues. I came out of both admissions with the worst anxiety I have ever experienced and was quite traumatised by some of my experiences in there. I was scared to sleep in my bed area during one admission as another patient wouldn't leave my area – I had PTSD.

Early intervention

Women consider that timely access to **appropriate interventions** will improve their experience.

— Easier access to treatment, more training for GPs. When I first attended my GP she said I wasn't sick enough to warrant psychiatric referral, despite my friends beckoning her to do so. She gave me a letter for the Emergency Department 'just in case'. This was eight years ago. To this day I think if she had taken me seriously I wouldn't have spent so much time in hospital and wouldn't have the long lasting physical effects that I have.

Alternatives to A&E for crisis support

— **Better access to crisis support** other than going directly to hospital A&E for assessment.

— Somewhere to go other than A&E or emergency services when in crisis.

Signposting

Greater awareness of community resources amongst staff in inpatient services may facilitate better recovery outcomes.

— I think if I had been directed towards support from charity providers and recovery colleges I would've had support from outside the HSE medical arena much earlier. This extra support from charities and Recovery College this is vital to my well-being but it took me years to make this association to my individual wellness.

Better information on treatment options

Women want information and consultation on treatment options.

— Making sure I was fully informed of all treatment options and medication risks etc.

WHAT WOMEN WANT

We have brought together the voices of all women who took part in the consultation for this section. This collective voice allows us to see clearly what can support and improve women's mental health service experiences.

WHAT WOMEN WANT

Women want to be listened to and be treated with dignity and respect

Communication and culture are important for all women and particularly so for women in inpatient services who may be very unwell or feeling vulnerable. In conversations women spoke of their commitment to recovery and finding ways of engaging with mental health professionals and services that facilitated respect for all.

— Really listen to me. Take into consideration what I'm saying.

Women want to be engaged in coproduction, bringing their lived experience as service users, to resolve communication and design issues in services. Women want to be involved in the physical design of inpatient units and other mental health facilities.

Women want improved communication. Suggestions include welcoming induction practices, information leaflets, or videos on how the inpatient unit works and what the rules and expectations are. The TIDAL and Safe Word models were recommended as good communication tools.

Language was also identified as important and terms such as ***'treatment resistance'*** were seen by participants as demeaning. Participants recognised this is a two-way process and indicative of a changing power balance between service users and staff.

— There's a controversial recommendation that Mental Health be known as BioPsychoSocial.

Women want more advocacy, safety awareness and peer support

– I feel every woman should be offered the support of an advocate or peer support especially in inpatient services.

A daily Key Nurse was also helpful and women want more dedicated one-one support in hospital.

Women want practical considerations in relation to smoking, the availability of vapes and women's sanitary care.

Women want alternatives to inpatient treatment. Home-based teams, day hospitals and access to 24/7 care is asked for.

— More time for appointments and different levels of intervention. Moving in-patient level of service into the community. Having a breakdown sometimes you need a bit more support but you don't want to go to hospital.

— Follow on care in the community would make mental health services better. You feel completely on your own when you come out of hospital.

Women want to feel safe.

— Women only wards

— Addressing trauma in women's lives, creating safe waiting areas for women, considering offering female only appointment times as many women would feel safer especially if they have experienced male violence or abuse.

Staff awareness of the impact of domestic violence is important.

— Dedicated PTSD treatment for DV, domestic violence, survivors. Professionals to include someone who is trained in domestic violence and can support a woman who needs mental health care to navigate her home situation, especially for those children involved.

Women want more peer support and advocacy

The support of peers is valued.

— A lot more peer support available within services, that is there for people when they feel they can't speak up and need someone to get it from their own experience of mental health.

— Apart from having someone to get support from and help to think solutions through, it would be nice if there was a drop-in centre to go to for support and to perhaps meet other women, maybe some form of peer support or even just a place open for a few hours a week a few times a week to meet other women looking for support. Over time they would help each other out.

The value of peer advocacy was also raised.

— When with the mental health services you were often not able to advocate for yourself. I felt very alone. There needs to be more support and advocacy. More female support.

Women want better access to mental health services including flexibility on location, appointment hours and offering online appointments.

— Quicker access to treatment is badly needed.

— Better referral pathways.

— The service required to support women's health should be made available locally so that those living in remote areas are not at a disadvantage. Even before issues arise the access to health care in rural Ireland is really poor.

— Receipt of appointments outside Monday to Friday 9-to-5. When you are on maternity leave and don't have access to child care it is virtually impossible to attend appointments so online appointment should be offered.

— More public services available after work hours and on weekends. Many people with mental health problems don't want to have to bring it to the attention of their employer if they need an hour each week for an appointment with the mental health professional. After hours services would be really valuable in enabling access.

— For all the length of a referral lists is ridiculous, if there were more community-based places to go just to participate in talk therapy in a group setting while waiting to be seen by the psych team. I think a lot of people would benefit from that.

Women want GPs and primary care nurses to be more aware of mental health difficulties and mental health pathways

— Knowledge and training so GPs can have direct access to a wider range of therapies beyond the bog standard counselling service.

— More direct links between GPs and qualified psychologists. Too much is left for people to do themselves, which is difficult for struggling people.

— Referral to the community setting rather than the Department of Psychiatry.

— I think public health nurses need to be aware of women's mental health especially mothers. They should be able to signpost and refer to Mental Health Services. Need more services visible and accessible in the community.

— Nurse practitioners dedicated to signposting and referring to mental health community supports would be good.

Social Prescribing was advocated in one conversation.

— Social prescribing can be really helpful, why is it a best kept secret? People are not getting information about supports out there. I never heard of Engagement Leads.

Women want greater access to free or affordable therapy including a variety of approaches that meets different needs.

— Better access to psychotherapy.

— Less stress on medication more access to psychotherapist.

— Psychotherapy services are needed, especially those that focus on talking about experiences and not just short-term interventions like CBT.

— Access to long-term talking therapy in family therapy.

Generally, a person-centred approach is advocated.

— More time invested on what individual patients really need instead of a one size fits all approach.

Women want the medical approach to be less dominant

The women who took part in this project expressed dissatisfaction with what they perceived a s a medication first approach to mental health difficulties. **The women who describe a consistent relationship with a consultant psychiatrist have indicated satisfaction with the service they receive.**

— Less reliance on junior doctors and trainee doctors in community teams. Seeing the psychiatrist is important and they should assess you personally. There needs to be a method by which cases are reviewed.

— More choice around the treating psychiatrist in the public system.

— **The biopsychosocial model needs to be key.** Issue is the health services are so under strain there is no time to spend with clients other than brief conversations. Needs more than 6 to 8 sessions. Some people need longer.

— Medication not the first option; more information on the impact of side-effects of medication. Evidence of what works and why.

— I would like to have more counsellors available just to talk instead of being prescribed more medication.

— *More listening, less reliance on medication and on certain psychological treatments. More attention that the person should be at the forefront of their own treatment plan.*

— Alternatives to medication e.g. vitamins etc. There is a stigma around medication.

— Nutrition, exercise general mental health support and good advice, not relying on drugs.

Women want a mind-body perspective on women's mental health

A lack of awareness amongst mental health professionals about menopause and confusion with mental health symptoms came up in conversation. Women want awareness brought to the impact of hormones on their mental health.

— Teenage girls need to be able to access mental health support, so when they need them, they have the best chance to have good mental health as they become women.

— Greater understanding amongst professionals of the connection between women's life stage and mental health. Hormones can have a massive impact on mental health and this is largely ignored or not discussed.

— There needs to be links grown between gynecologists, psychiatrists and psychologists to understand how hormonal cycles and things like Endometriosis can affect women's mental health.

— Greater recognition of the influence of hormones and oral contraceptives on mental health.

— Greater appreciation of the impact of menopause and care of families especially elderly parents. Young mothers working full time is also a great strain on women's mental health and very young children's mental health.

— More help needs to be available to women who experience postnatal depression, postnatal psychosis. There are currently no arrangements for an unwell mother to be with her baby in a setting where she needs mental health care. There also needs to be more awareness into premenstrual dysphoric disorder, as many women suffer horrifically with their mental health during their cycle.

WHAT WOMEN WANT

Women want greater support for families

The support needs of women parenting alone and those of family members were highlighted during the conversations.

— Support should be in place for families and supporters.

— More support from others for women parenting alone.

— Greater appreciation off the demands we have trying to balance, work and family life while unwell.

— Child care to be provided if someone has an appointment and doesn't have anybody to mind the child. Services and follow up during and after pregnancy, postnatal depression. Education is poor.

— Better understanding of the needs of women accessing the service. Awareness of the pressure society places on women as mothers and wives. Focus on the needs of the woman in crisis not diverting attention to the needs of her family.

WHAT WOMEN WANT

Women want improved services for Eating Disorders, Autism and ADHD

Assessment and intervention for people with ADHD and Autism was raised by a number of women.

— Mental health support specifically for autistic women who have very different needs. Women should have assessments for autism/ADHD etc. I was assessed as being depressed when in fact have been autistic and undiagnosed, was a significant issue. No health professional encountered even considered this.

A number of women called for awareness of Eating Disorders and better service provision.

— Better understanding of eating disorders with better communication with staff and patients.

— Greater awareness of the mental health impact of disability and long-term health conditions.

Women want information, education and training on mental health

Women are looking for more information about how services work and what support services are available in their locality.

— Information sessions locally, libraries, mum groups etc, about what is available in that area.

– I feel there is a lot of supports, but the promotion of the supports needs to be better so people know, on a national level, where to go for these supports.

Women have asked for training for professionals on stigma and unconscious bias.

— Training on unconscious bias for all providers.

— The stigma and misinformation, even from health professionals, needs to change.

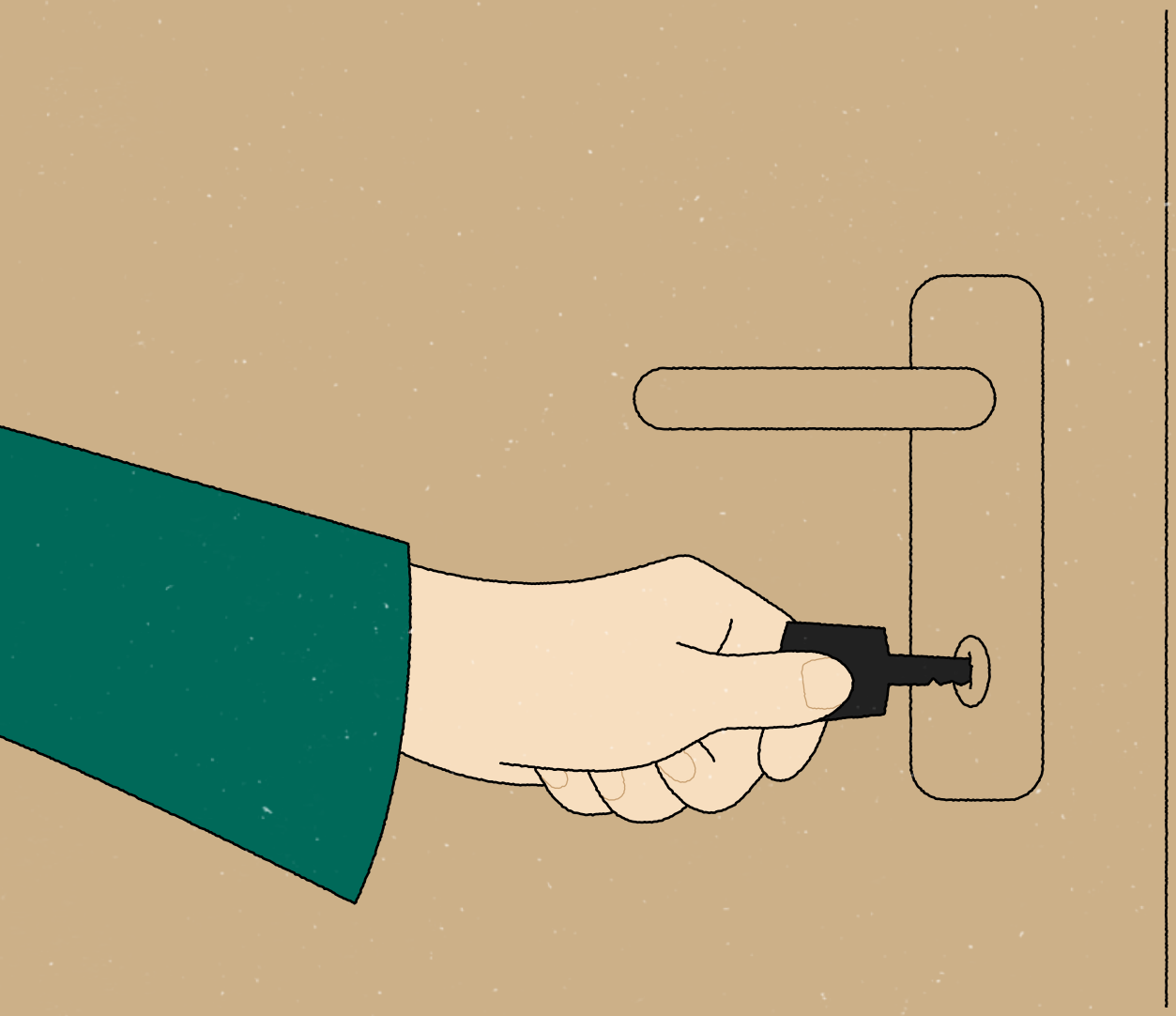
Education for young people is considered a priority by the participants.

— Classes on how to deal with mental health issues in school, especially 6th year.

— Teaching girls that mental health is as important as physical health.

— Interventions for schools. Education for school kids and life skills.

– Information should be up about HSE MH services, engagement and Recovery supports, in every pharmacy, GP surgery, library, supermarkets, garda stations, community centres. Like a snapshot A4 page.



Reflection

The perspectives gathered in this report make it clear that the services and supports that could best respond to their needs are **integrated, accessible, person-centered mental health services in primary and secondary care.**

The strong call for ***more psychologists*** and ***more than medication*** reflects a change in model, a **move from medical treatment as the perceived dominant lead to a biopsychosocial approach** to mental health. Medical treatment alongside more therapeutic interventions - in particular psychological approaches - within primary care and community mental health services are suggested.

The majority of women understand that staff and services are committed to supporting them but want to see the approach change.

> — *They don't want to see us unwell, they want to see us get better. Need to change the mindset from a medicalised approach.*

This view is underscored by the many references to a **mind-body understanding of mental health** and how it interacts with physical functions. Of particular note is the need for mental health services to understand and appreciate women's mental health throughout the life cycle with specific consideration of hormonal changes, menopause, perinatal and postnatal experiences.

— Women have to justify themselves so much when it comes to mental health needs especially when pregnancy, birth or menopause cause or contribute to the problems.

The desire for timely access to services and the women's view that more therapeutic intervention is needed at both levels of care underscores statements in ***Sharing the Vision, a Mental Health Policy for Everyone, 2020***:

> ***"While initiatives such as Counselling in Primary Care (CIPC) have been introduced, there is still insufficient access to these types of supports in primary care. This, in turn, has contributed to an over reliance on specialist secondary care systems, resulting in waiting list for such care in various mental health services."***
>
> – Sharing the Vision p.40

Gender was not considered a differentiating factor accessing services, however, **gender is a factor for women once they experience services**. Women's experience of their mental health difficulties alongside menopause, postnatal difficulties, childcare challenges, domestic abuse, neurodivergence, medications, and safety tells us that, for the most part, women's needs in the development and delivery of mental health services can be considered further.

An **alternative to the use of A&E to access crisis support** was highlighted. Some women had fortunate experiences and describe the positive impact of home-based teams, day hospital care, and individual support from a community mental health nurse or a nurse on call, in getting through a difficult period.

A majority of women reported some satisfaction with the service they receive from the HSE Mental Health Services and private mental health services. While accessing services is generally difficult, once in the system the **consistency of the relationship with mental health professionals and respectful treatment greatly influences women's satisfaction with services**. A consistent relationship with a consultant psychiatrist and a person-centered, recovery-focused team of nurses, occupational therapists, social workers, and clinical psychologists provides the range of support required. Junior doctors on rotation do not provide the consistency of relationship women need.

Women want to be treated with kindness and they want to feel safe when in hospital; sharing wards with men, seclusion in padded rooms, having open showers and toilets and removal of mobile phones and notebooks were among the distressing experiences women spoke of. Risk management in the design and operation of inpatient services can ensure women's sense of safety and dignity, and be informed by the core values of ***Sharing the Vision*** - respect, compassion, equity, and hope.

The **importance of community-based and peer support** is evident in the women's responses. Equitable access to peer support workers, recovery colleges, and peer support projects and groups, throughout the country will support women's mental health in the community. **Women want the public and health professionals to be better informed of the range of mental health services and support available in local communities.** GPs as the first port of call are key as are professional mental health staff in hospital and community settings. Both can be primed to signpost to additional community supports such as Aware, Shine, Grow, Peer-led projects and Recovery Colleges.

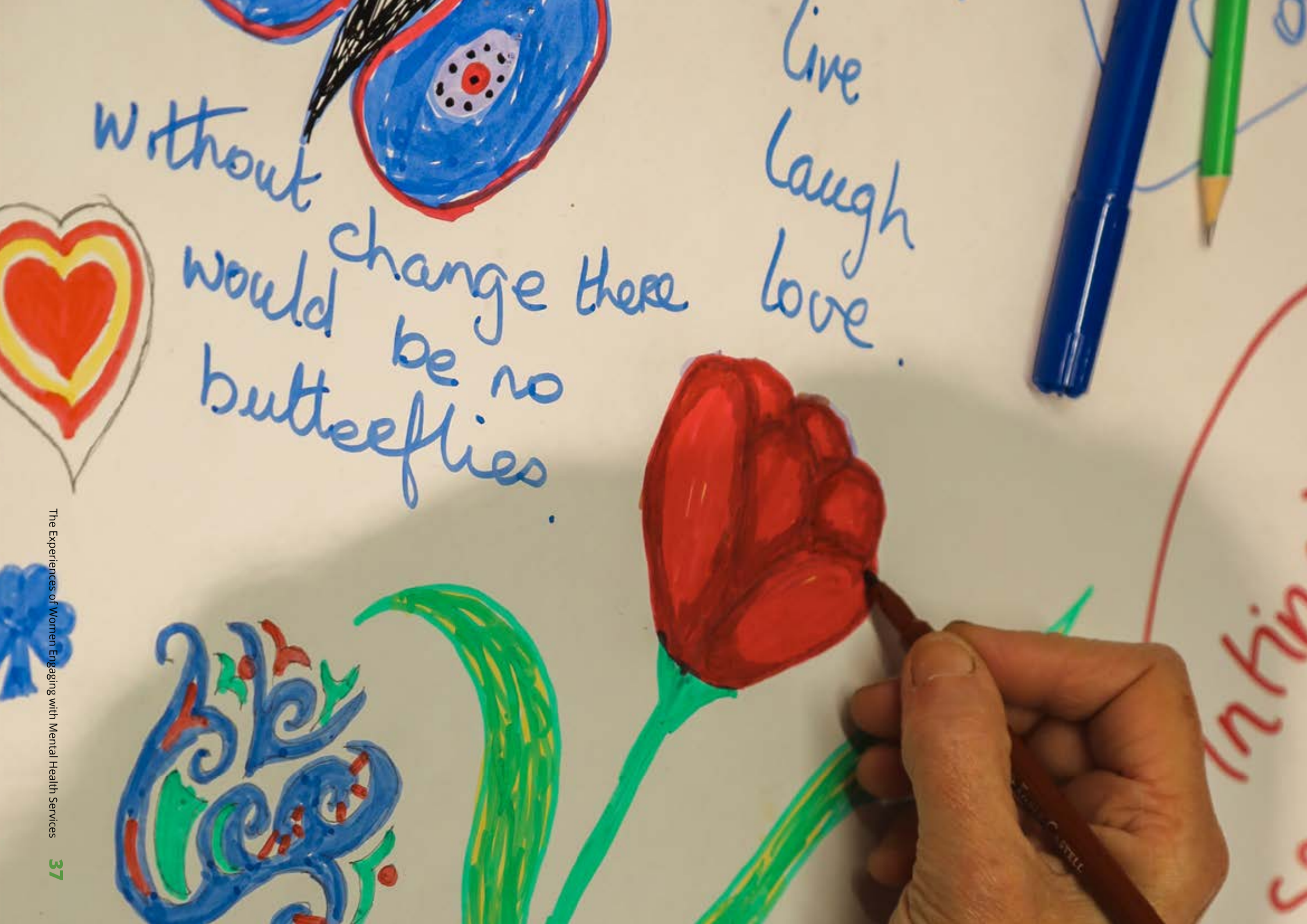
Women also expressed the need to **educate the public about mental health services**. What are they? Where are they? Who are they for? What treatments are available? What are your rights within services?

Equity of access to mental health services is paramount. Women who accessed private services because they were desperate and had the financial means to do so are keenly aware of the fact that cost may impact other women's access to timely care. Rural access was also considered a challenge.

Underpinning future change is the **involvement of service users, family members, and carers** alongside mental health professionals in the design and development of mental health services.

— Design in an appropriate way. Coproduce and codesign with people who understand services.

It is heartening to note that many of the desires that women have expressed in this consultation are planned for in the Sharing the Vision implementation plan and the work of the Women's Health Taskforce. This report also reminds all stakeholders that we have a personal responsibility to engage in a kind and compassionate manner at all times. This is a responsibility underpinned by the first of Slaintecare's principles *patient is paramount.*


Without change there would be no butteeflies.
live
laugh
love

Thank you

A warm thank you to all the wonderful women we met and heard from during this process, thank you for sharing your experiences and ideas with us.

National Office of Mental Health Engagement and Recovery

HSE Mental Health Services
St Loman's Hospital, Dublin

Email: mhengage@hse.ie

www.hse.ie/eng/services/list/4/mental-health-service/mental-health-engagement-and-recovery/