Gender-sensitive Mental Health:

Developing Policy and Services Which Meet the Particular Needs of Women and Girls

Quality Matters
supporting improvement in social services

National Women's Council

Contents

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1. List of Abbreviations:

AMHS	Adult Mental Health Services
CAMHS	Child and Adolescent Mental Health Services
C&VS	Community and Voluntary Sector
CHO	Community Health Organisation
CSO	Central Statistics Office
DV	Domestic Violence
ESRI	Economic and Social Research Institute
GSMH	Gender-Sensitive Mental Health
HSE	Health Services Executive
IPV	Intimate Partner Violence
NWC	National Women's Council
STV	*Sharing the Vision*

2. Executive Summary

Introduction

This research examines current best practices in gender-sensitive mental health care, maps current practices and gaps in practices in Ireland and, based on the findings from the literature and qualitative research carried out for this report, identifies comprehensive recommendations for the delivery of a gender-sensitive mental health care system for women and girls.

Gender has been recognised by the World Health Organisation as a critical determinant of mental health and illness and there is growing awareness of the need to consider policy and practice through a gendered lens. Gender-sensitive approaches to health care recognise how socio-political and cultural factors, in addition to biological factors, shape care needs, care delivery and impact of health outcomes. Gender sensitivity considers the impact of multiple marginalisations (for example, when gender intersects with race, ethnicity, disability, and socio-economic factors). A gender-sensitive approach to the design of health systems attempts to embed awareness of, and devise solutions to, the structural inequalities which result in some groups of the population having worse health outcomes than others.

This research has been carried out to support the implementation of Ireland's national mental health policy, *Sharing the Vision*, and in particular Recommendation 16, which emphasises the need for a range of counselling supports and talk therapies be available to people with mild to moderate mental health care needs in community/primary care settings. The recommendation states that those services should be provided based on identified need and across the lifespan. However, so far the needs of people from a gendered perspective, in particular the needs of women and girls, have not specifically been identified or provided for either in policy, strategy or practice. We propose that the implementation of *Sharing the Vision* can be more sensitive to the key issues described in this report and gender sensitivity can be integrated into formal implementation plans throughout the lifetime of *Sharing the Vision*.

The need for a gender-sensitive approach has been highlighted in various reports from National Women's Council and The Women's Health Council. The aim of this report is to further clarify how this approach could be effectively embedded in mental health services in primary care services and community settings in Ireland, through the following three objectives:

1. To map best practice in the provision of mental health services to women and girls.
2. To assess understanding of, and current best practices in, gender-sensitive mental health (GSMH) in Ireland, across existing mental health service provision.
3. To provide recommendations based on the evidence gathered from stages one and two on how best to develop policy, strategy and practical next steps in the provision of effective, targeted mental health care services of women and girls.

The report has two sections. The first half of the report consists of two state-of-the-art literature reviews. The first review examines the experiences of women and girls accessing mental health services through an intersectional lens. The second looks at contemporary international research and research specific to Ireland; mapping current best practices in GSMH provision. The second half of the report outlines primary research findings from interviews and focus groups conducted with 32 people from mental health services and mental health referral services in the Republic of Ireland. The objective of the qualitative research was to determine:

1. The level of knowledge currently in Ireland on GSMH practices within the HSE and among other relevant stakeholders.
2. What was currently being done in terms of mental health provision from a gender-sensitive perspective by services providing mental health supports or referral to mental health supports to women and girls.
3. What practical steps could be taken in a move towards a more GSMH service for women and girls in Ireland.

Key Points from the Literature Review

The literature reviews examine state-of-the-art research from the last five years and consolidate what is well established in relation to the experiences of women and girls from minoritised groups. It emphasises the need for comprehensive gender sensitivity in establishing effective mental health services for women and girls.

Themes from the research relate to:

- the low prevalence of gender sensitivity among professionals and in services overall
- how the needs of women and girls are highly sensitive to context, intersectional factors and the social determinants of health
- the need for person-centered approaches and flexibility in delivery in order to facilitate accessibility and success.

Key best-practice features were identified for the development and delivery of gender-sensitive mental health care. These are condensed from the full report below:

Comprehensive training and staff support

Professionals, including the medical and nursing professions, need to be trained in gender-sensitive care, including recognising their own gender biases. Training should also include cultural competency and cultural humility as standard in continuous professional development (CPD) and these modules need to have gender sensitivity integrated into the material. Training must include contemporary evidence and be tailored to increase awareness of the specific needs of specific groups such as the Traveller and Roma Communities, asylum seekers and refugees, and specific ethnicities and groups including, but not limited to, people from African countries, Central and Eastern Europe (including Ukraine), and Muslim communities. Training should also consider gender diverse identities and their specific needs.

A service user-centred approach grounded in the specific needs of women and girls

Women, with specific representation from marginalised groups, need to be included in service planning and design. Service design needs to include a choice of different therapeutic options which include in-person and online options.

In order to continually improve services and understand if design changes are having the desired impact, mental health service provision to women and girls needs ongoing review. This requires systems to be established that collect disaggregated data on needs, access and outcomes for different groups of women.

Flexible and accessible service delivery

Service design also needs to mitigate gender-specific barriers to care. This should include, but not be limited to financial barriers, care responsibilities, access to technology and the needs of women and girls experiencing violence and abuse. Key methods to reduce barriers include offering timely, free, and flexible therapy to women and girls, and ensuring that services are culturally informed, as well as ensuring access for women without the means to attend in-person, due to finances, caring responsibilities or rural location. Remote and online types of therapy should be made available as an option, but not as a replacement for community-based support. Strengths based supports also need to be made available within community settings, and outside typical hours with as accessible referral pathways as possible.

A life-course approach to service design

Professionals need an awareness of the ways in which trauma impacts people differently by gender, and how this varies across the life span. The variation in presentation and coping mechanisms with regard to trauma across genders warrants further consideration. Gender sensitivity is required at all stages of the life span, from birth through adolescence, midlife and menopause and older adulthood. GSMH training programmes with a biopsychosocial approach on differences across lifespan for current practitioners (GPs, mental health professionals, nursing), are recommended. These should take account of the complex interaction of the unique physiological, hormonal, environmental, social and psychological needs of women and girls.

Policy needs to enshrine a gender-sensitive lens into all the planning and review of all mental health care and primary care programmes with a focus on prevention, early intervention, accessibility, and care efficacy.

Key Findings from Qualitative Research

> Gender is something we can't ignore and I mean that from an intersectional perspective. For example, women of colour, lesbian women of colour all have differing experiences and needs. It's our job to educate ourselves. We can't be passive; we have to be active and proactive. **Interviewee 11, NGO**

Overall, nineteen themes, listed below, emerged from the analysis of the interviews with stakeholders and the focus groups.

Lack of women's representation

1. **A gendered lens is absent from policy and strategy.** An overall lack of visibility and specific policy targeting women and girls was observed by the experts interviewed, as was a lack of gender sensitivity in strategy. Importantly, it was noted that *Sharing the Vision* and *A Vision for Change* would benefit from a gender lens in order to address the specific needs of women and girls.

Staff training needs

2. **Self-assessed practitioners' knowledge of GSMH varies widely among professionals,** which is a reflection that this is not currently embedded in primary education programmes, or adequately provided for in CPD courses for existing practitioners.
3. **Need for additional cultural diversity and intersectional sensitivity.** Interviewees highlighted the continuing lack of cultural sensitivity and humility in the provision of services. This results in needs not being met due to a lack of understanding of cultural values and practices.
4. **Addressing gender bias and unconscious bias in the delivery of healthcare.** Gender bias and unconscious bias was considered prevalent and ongoing issues, echoing findings in the literature review.

Barriers to women's access to mental health services

5. **Need for choice and flexibility e.g. online and in-person therapeutic supports.** Women experiencing intimate partner violence, women in Direct Provision and women seeking international protection, older women and women in rural areas needed choice with regard to the mode of delivery of therapeutic supports.
6. **A lack of housing and income have an outsize effect on women's access to mental health care.** Women facing financial burden, poverty and homelessness were disproportionately affected by these barriers to inclusion.
7. **A two-tiered, overburdened health system results in marginalised groups not getting required services.** The current conditions of the health care system were a major barrier to women accessing services.
8. **Social prescribing and other proven early intervention and prevention strategies require more resourcing.** Interviewees supported the extension of

the social prescribing and other community initiatives which were effective in preventing the escalation of mental health issues.

The additive impact of intersecting factors for women

9. **Domestic and intimate partner violence have a serious impact on women and girls mental health.** The current model where women and children enter refuges and leave the family home destabilises women and children, and the system can favour the perpetrator in terms of home and financial security.
10. **Addiction frequently deprioritises women's mental health** Women in addiction need concurrent access to mental health services, and a removal of existing barriers that state or imply that addiction needs to be treated first.

> Addiction cuts across so many areas. Adults abused as children; addiction often has that back story. It impacts how mothers can care for their children. They may avoid services, keeping themselves and their children safe is the focus. **Interviewee 2 HSE**

11. **Women seeking international protection have a complexity of needs.** Newly arrived ethnic minority women, particularly women fleeing trauma and war have specific needs, which are often poorly understood. The necessity for participation of women from those groups in the design and delivery of services was essential.
12. **Pathways to care for women who are trans need to be improved.** The specific needs and experiences of trans women was a cause for concern for a majority of contributors. The very long waiting lists for accessing gender clinics and serious gaps in service provision for gender affirmation supports and interventions were also identified barriers.
13. **Lack of childcare is a significant barrier to accessing services.** A majority of interviewees highlighted childcare as a considerable barrier to women in accessing mental healthcare supports. This was due to financial and time constrains, as well as the fact that the burden of care and emotional labour in many households falls disproportionately to women.
14. **Menopause is not given sufficient consideration in policy or practice.** Menopause was viewed as poorly understood and inadequately supported in medical and mental health care. A deeper understanding of menopause, how to accurately assess for and treat the symptoms of menopause was of critical concern. Perceived misdiagnosis of hormonal or conversely mental health issues was considered a common issue.
15. **The impact of stigma and shame.** Stigma and shame were more common in certain groups of women than others. In particular, resistance to accessing mental health services was more common among Muslim and African communities and for Ukrainian women seeking international protection. This was also an issue for new mothers and for women in more rural settings.
16. **People living in rural areas have disproportionate barriers to access services.** Barriers include time needed to travel and additional travel costs for accessing specialised services, which are often based in urban areas.

17. **Isolation and combined physical and mental health needs have a significant impact on older women's mental health.** Women have a higher life expectancy than men and some women may experience isolation in later life. Women from minority groups (e.g. lesbian and ethnic minority women) in residential settings may experience an amplified sense of isolation. There may also be restrictions with regard to pet ownership in rented accommodation which can be difficult to accept.

18. **Perinatal mental health needs to be further understood and supports provided for specific groups of women.** A minority of interviewees discussed perinatal care and the need for the expansion of the current hub and spoke model for supporting the large cohort of women who experience perinatal mental health issues. Specifically, the tailoring of perinatal supports for specific groups of women e.g. Traveller and Roma women and strategies to tackle the lower mortality rates of infants in these communities.

The role of social media

19. **Social media can be a protective or risk factor.** Online harassment and bullying, and the frequently personal and gendered nature of the bullying and harassment was an issue raised by a minority of interviewees. Conversely the positive impact of social media was highlighted, particularly for younger women and newly arrived ethnic minority women who could remain in contact with family or access community-specific wellbeing supports online.

Summary of Recommendations

These recommendations were co-developed with principal stakeholders, and are based on the findings from the literature reviews and the qualitative research conducted for this report. The literature reviews identified good practice guidelines namely:

- The need for gender-sensitive interventions
- Addressing the lack of gender sensitivity among professionals
- Gender sensitivity is a core component of trauma-informed care
- Flexibility in approach, especially with those from marginalised backgrounds
- Accounting for gendered differences across the lifespan.

Strengths and deficits in current practice in Ireland were identified in the thematic analysis of the conducted interviews and focus groups. The objective of the co-creation of these recommendations was to develop tangible and achievable actions based on the findings of this report. The summary of 31 recommendations is presented based on the Centers for Disease Control (CDC) framework for effective implementation of policy and strategy grounded in the World Health Organisation's social determinants of health model. The CDC is the national public health agency of the United States, however it is relevant in the Irish context as this model focuses on the non-medical factors that influence health outcomes and provides a useful framework for future action.

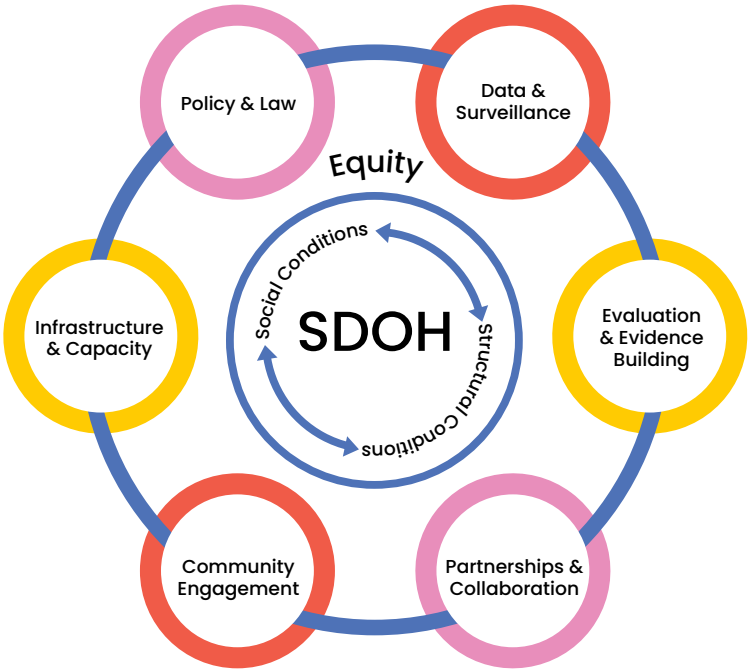

Figure 1. The Centers for Disease Control Social Determinants for Health Implementation Framework.[1]

Policy and Law

1. Increase mental health funding as a portion of the health budget to deliver on the ambition of *Sharing the Vision*, particularly so services can reach most marginalised and to allow for targeted services for women and girls.
2. Develop a clear strategy to increase the representation of marginalised groups from a range of backgrounds in the overall workforce of mental health practitioners, therapists and counsellors.
3. The HSE to develop a counsellor grade which would remove barriers for qualified counsellors with accredited qualifications to deliver mental health supports within the HSE and help to increase capacity.
4. Adopt a 'mental health first model', so people with a dual diagnosis of addiction and mental health are not denied mental health supports.
5. Failing the abolition of Direct Provision, gender-specific accommodation should be provided as an option.
6. Examine current civil and criminal domestic violence legislation, with a view to putting mechanisms in place that do not unduly penalise the survivors of abuse especially with regard to staying in the family home.
7. Consider extending protections afforded to partners of abusers (which are already in place) to children and adult children of parents and carers in the family home e.g., protection order mechanisms which can be triggered for children and adult children living at home who are the victims of domestic violence.

1 Framework developed by the Centers for Disease Control and Prevention for addressing the social determinants of health (SDOH), (Hacker & Houry, 2022).

8. Given the move to community embedded mental health services for people with high needs and other presentations, align mental health assessment for access to services with recovery-led, person-centred care as opposed to DSM/ICD criterion currently used.
9. Housing authorities to develop a common protocol to ensure the non-discriminatory provision of shelter and accommodation for trans people
10. Expedite legislation on hate speech.

Data and Surveillance

11. Relevant agencies such as the HSE, CSO and ESRI to collect disaggregated data which includes demographic identifiers and Ethnic Equality Monitoring that will support an assessment of accessibility of mental health services to all marginalised groups and support a gender analysis of access and efficacy of services.
12. The new integrated Case Management System (ICCMS) which will soon be in development as a national electronic health system for patients, clinicians, administrators to manage all aspects of planning in relation to health care across community services should ensure data is captured by gender, (providing interoperability with acute hospital systems).
13. Make reporting of gender differences in all drug trails compulsory.

Infrastructure and Capacity

14. Integrate comprehensive GSMH training into third level training programmes in mental health.
15. Develop and deliver intersectional GSMH CPD training to mental health and primary care health practitioners.
16. Uncouple access to mental health services from home addresses for people without a permanent home, developing a protocol for women who experience domestic violence or are in Direct Provision
17. Promote an understanding of GSMH, as an approach, through literacy campaigns targeting medical and mental health providers.
18. Adapt payment schemes so that services can provide hourly drop-in or booking based childcare options for parents and carers of children aligned with primary and community mental health settings.
19. Ensure that as many women as possible have access to a choice of online and on-phone counselling, in addition to in-person mental health services. This will be particularly important for supporting access for women from the disabled community.
20. Extend the free travel initiative to people who are homeless and people in Direct Provision.
21. Provide funding for extended mental health consultation time to GPs, similar to the current abortion services provision time, to deliver psychological first aid brief intervention to people experiencing mental health difficulties.

Community Engagement

22. Bolster social prescribing initiatives, ensuring these are available nationally, supporting their role in early intervention for mild mental health issues.
23. All state funded mental health services to provide a choice of therapist by gender to enhance choice and empowerment.
24. Develop a range of initiatives to reduce shame and stigma around mental health and support seeking, targeting marginalised communities and using community development approaches.
25. Consider culturally sensitive modes of delivery of mental health supports including group therapy models for specific cohorts (e.g., women from Muslim communities, Traveller women)

Partnerships and Collaboration

26. Review and strengthen early engagement and onwards pathways to mental health supports for groups who face significant additional barriers to service access groups, particularly where there is stigma associated with mental health issues. For example identify specific engagement strategies for women and girls from Muslim communities, Ukraine, Roma and Traveller communities that are developed with participation of members of those communities.
27. Develop drop-in community-based mental health support services with outreach teams to support access to care for women in the commercial sex trade and those who have been trafficked.
28. Co-ordinated advocacy to focus on calling for a housing first model, and adequate housing supply.
29. Develop evidence-based interventions addressing the impact of social media, porn, online harassment, and the social pressures and expectations these fuel, on the mental health of women and girls.
30. Develop systems within primary care for the early identification of mental health needs in early life, particularly school age years. This should be carried out in collaboration with schools and community mental health teams.

Evaluation and Evidence Building

31. HSE Mental Health Services to undertake an assessment of mental health services, mental health services in primary care, community-based supports and health and wellbeing initiatives against the findings of this report and develop an action plan to implement key changes.

3. Introduction

Gender has been recognised by the World Health Organisation (Sayers, 2001) as a critical determinant of mental health and illness and there is growing awareness of the need to consider policy and practice through a gendered lens. A gender-sensitive approach recognises how the socio-political and cultural context, in addition to biological factors, shape care needs and care delivery. This approach also acknowledges how gender affects access to and experience of health care, as well as presentation of need, particularly for women and girls. Particular challenges to access and greater levels of need can be seen for women experiencing multiple marginalisation (for example, when gender intersects with race, ethnicity, disability and other socio-economic factors). A gender-sensitive approach attempts to embed awareness of these wider structural inequalities into the design of health systems and the delivery of health care, and in doing so, attempts to mitigate the impact of these.

The purpose of this research is to examine the ways in which gender-sensitive mental health principles may be implemented within primary care services and community-based mental health settings to better support women with mild to moderate mental health difficulties. To date, there has been limited qualitative research with service providers in this area and as such this report adds value by:

- Providing insights into the extent of knowledge of gender sensitivity strategies and measures of practitioners or providers in Ireland
- Examining the extent to which gender-sensitive principles are implemented in primary care or community based mental health supports in Ireland
- Identifying best practices for gender-sensitive mental health services in Ireland
- Offering recommendations for how services can begin the process of becoming gender-sensitive which is grounded in practitioners' insights

There is substantial evidence to support the need for gender-sensitive approaches to mental health, and such approaches are aligned with national strategies and frameworks to support and optimise mental health. This introduction outlines the salient research conducted in Ireland to date and gives an overview of the policy context within which this report is situated.

Within the Irish context, gender-sensitive mental health (GSMH) has been a topic of interest for a number of years, with several publications indicating the need for, and importance of, GSMH in Ireland. For example:

- *Women's Mental Health in Ireland Briefing* (National Women's Council, 2020): This document outlines the importance of gender, and how it can impact mental health, difficulties in accessing treatment, and the unique vulnerability of marginalised women and girls.
- *Out of Silence* (National Women's Council, 2018): This large-scale study of women's experiences of mental health in Ireland involved consultation with a range of women from diverse backgrounds, including members of the Traveller and Roma communities, older and younger women, single parents and women of migrant background. The report highlights the need

for better provision of support to women, through early prevention, training of professionals, providing adequate and suitable support, and making care accessible.

- *Healthy Ireland Survey 2021* (Healthy Ireland Survey 2021): This large scale study of health in Ireland provides a strong basis of evidence for differences in mental health needs among men and women, and highlights the particular vulnerability of girls and women aged 15-24.
- *Improving the Health Outcomes and Experiences of the Healthcare System for Marginalised Women* (National Women's Council, 2021): This report, based on qualitative research with 50 women from diverse backgrounds, details the unique challenges and needs of women from marginalised backgrounds in accessing healthcare and recommends factors such as: gender sensitivity training, person-centred care, community-based support, accessibility of services, and cross-governmental collaboration.
- *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision* (Women's Health Council, 2004): This document provides background, justification, and necessity for the implementation of gender sensitivity in mental health care and calls for a shift from the biomedical approach to treatment.
- *A guide to creating gender-sensitive mental health services* (The Women's Health Council, 2007): This document provides an outline of how gender sensitivity can be mainstreamed within the development and implementation of mental health services.

The policy landscape has also developed considerably over the last couple of decades with gender awareness taking on greater prominence. The *A Vision for Change report of the Expert Group on Mental Health Policy,* published in 2006 (Department of Health and Children, 2006), outlined specific areas of mental health supports warranting a gendered perspective to better support women, in particular perinatal care, certain presentations of self-harm and disordered eating. However, broader consideration of gender-sensitive practices and principles were absent from this policy framework (Bergin et al., 2013). *Sharing the Vision - A Mental Health Policy for Everyone* and the *Sharing the Vision Implementation Plan, 2022 – 2024*, (Department of Health, 2020, 2021, respectively) built on the ambitions of *A Vision for Change* and set out an up-to-date strategy for mental health services provision for all.

Notably, within *Sharing the Vision* (Department of Health, 2020) and in a break with past policy, gender-sensitive mental health is included as both a recommendation and a key action for the Department of Health over the coming years. The need for this approach is further expounded in the implementation plan for the strategy, *Sharing the Vision Implementation Plan 2022-2024* (Department of Health, 2021), which outlines the need to:

- Ensure that mental health policies are gender-sensitive
- Ensure women's mental health is adequately addressed through implementation of policy

- Ensure the inclusion and empowerment of all people and families accessing mental health services.

The National Implementation and Monitoring Committee, the body charged with overseeing roll-out of *Sharing the Vision*, established a Specialist Women's Mental Health Group to provide a particular focus on gender-sensitive healthcare and improving women's access to and experience of mental health support, which NWC is a member of. The rationale for this report builds on the work of this Group and is grounded in *Sharing the Vision*, particularly recommendation 16, which states:

> Access to a range of counselling supports and talk therapies in community or primary care should be available on the basis of identified need so that all individuals, across the lifespan, with a mild-to-moderate mental health difficulty can receive prompt access to accessible care through their GP or Primary Care Centre. **(Department of Health, 2020)**

This recommendation was identified as being of particular importance to women and girls given their higher rates of affective disorders such as anxiety and depression (Altemus, 2006), and their preferences for talk therapies to assist with this(McHugh et al., 2013; National Women's Council, 2018). The HSE has stated that over 90% of mental health needs can be successfully treated within a primary care setting, with less than 10% needing to be referred to specialist community mental health teams, (HSE Mental Health Service, 2019) therefore with appropriate investment and tailored service development, implementation of this recommendation has significant potential to prevent mental health problems deteriorating.

Within an international context, *Sharing the Vision* is among the more comprehensive approaches to population mental health. It includes a range of actions that have a 'whole-government' approach, including but not limited to: the inclusion of multiple departmental bodies in progress monitoring, a focus on marginalised groups, and the explicit inclusion of women and girls within the policy remit (McDaid et al., 2022). Overall, while Ireland is in a strong position currently in terms of the ambition of the strategy, the success of the strategy will require effective implementation, and an intersectional gender-sensitive approach to ensure that all women benefit from its implementation.

The *Women's Health Action Plan* (The Department of Health, 2022b) embeds a team responsible for the rollout and implementation of a comprehensive women's health strategy. The strategy is based on a series of Radical Listening exercises and is designed to respond to the diverse needs of women in Ireland. The strategy recognises that ethnic minority and other minority women require targeted supports; a sentiment mirrored in the recently published *National Traveller Health Action Plan for 2022-2027* (Department of Health, 2022). That plan includes six mental health objectives and recognises that further minoritised groups within the Traveller Community, including women, require additional and specific supports.

Ongoing monitoring, and the collection of high-quality data will help ensure the Women's Health Action Plan, is achieving its goals for all women. The most recent Sláintecare Action Plan (Department of Health, 2022), highlights the need for a population segmentation framework and analysis, the development of which is currently underway. The Sláintecare Progress Report states that the segmentation of data in this way:

> '…will address health inequalities by ensuring that all areas of the population are appropriately represented in how we plan and fund services.' **(The Department of Health, 2021) P. 30**

The implementation of well segmented data will take some development for this to be consistent and useful. However, it is necessary for the successful implementation and evaluation of gender-sensitive strategies. For example, the HSE's recent report on the rollout of a Chronic Disease Management programme, part of Sláintecare's strategy, breaks down the overall population served by sex but does not give breakdowns by sex or gender in the rest of the report. Population segmentation data comprehensively applied to all such initiatives could provide very valuable information on effective, targeted healthcare going forward.

All of the policy and strategy documents mentioned in this introduction emphasise the person-centred, recovery-led and participatory principles of *Sharing the Vision*. This research aims to support and deepen an understanding of how these strategies can be achieved. The focus of this report is examining in practical terms, and according to healthcare professionals at various levels of the system, how a gender-sensitive perspective could assist with making sure that women are equally benefiting from mental health services in Ireland.

4. Literature Review

Overview

This review forms part of a mixed methods study into gender-sensitive mental health care (GSMH) in Ireland for women and girls with mild to moderate mental health needs. As such the review considers community-based supports for women and girls and the provision of, principally, non-pharmaceutical talk therapies, supports and interventions. The purpose of this literature review is to explore emerging international research (from the past five years) on the experiences of women and girls in relation to mental healthcare. The review also examines the ways in which gender-sensitive mental health principles may be implemented and mainstreamed within primary care and community-based mental health support services in Ireland.

The literature review begins with a definition of gender-sensitive healthcare. This project builds on research carried out by the National Women's Council, and The Women's Health Council, which is outlined in more detail in the second section on Irish strategy, policy, and research. Then methodology and search strategies are described. Sources include contemporary international research, as well as research based in Ireland.

The review addresses three main questions:

1. What are recent research findings about the experiences of women and girls in relation to mental healthcare?
2. What practical supports can be put in place to improve the experiences of women and girls accessing mental healthcare in Ireland, and what is best practice in relation to gender-sensitive mental health?
3. Recently there has been a move to online mental health support, which grew during the pandemic. For example, online CBT is now provided by health service providers. What guidance can be gleaned from the literature about online compared to in-person mental health support?

The results are reported by narrative synthesis, and followed by a general discussion. The review concludes with a summary of recommendations from each of the three themes.

Methodology for the Literature Review

Overview

The reviews included results of two systematic searches of five separate databases: CINAHL, Cochrane Library, EBSCO, PsycINFO, and PubMed. Inclusion criteria required studies to be published in peer-reviewed journals in the areas of psychology, public health, or medicine; published in the English language, and published within the past five years.

Search strategy for the experiences of women and girls accessing mental health services

This section sought to understand women and girls' experiences in mental health or primary care, exploring any peer-reviewed literature from the past five years. The following search strategies were used:

> ["wom*" OR "girl*"] AND ["access*" OR "experience*" OR "Barrier*"] AND ["Mental health" OR "Psychotherapy" OR "therapy" OR "counselling"]

Results of this search yielded a total of 3,305 articles. These were sorted by relevance and the first 100 were selected for screening. Title and abstract screening removed 58 papers as they did not relate to women and girls' experiences in mental health or primary care, leaving 42 to progress to full-text review. Of these 42, a final number of fifteen studies were included for this review as they specifically explored the needs of women and girls in primary care and mental health.

Good practice review

The following search strategies were used for the good practice review:

> ["Gender-Sensitive mental health"] OR ["GSMH"] OR ["gender differences" AND "mental health"] OR [Gender specific mental health"] OR ["gender sensitivity" AND "mental Health"]

The search resulted in a total of 188 papers, suggesting a very small number of articles addressing this issue. The first 100 articles were screened by title and abstract for relevance. To capture all potentially relevant factors, coverage of the following areas determined eligibility: gender-sensitivity in mental health, gender differences in mental health needs, community-based and/or primary care mental health, and gender in the context of patient-provider relationships. Upon completion of screening, a total of 41 papers were then progressed to full-text screening, and 25 articles were retained for final analysis.

Additionally, more targeted searches were conducted to explore quality of care for women and girls from minoritised or marginalised backgrounds. This area was identified by the Research Advisory Group as requiring specific focus in preparation for this review, as much of this literature would be missed in the wider search strategies used. For example, the search strings were modified to include the terms 'minority', 'socio-economic status', 'minoritised' and 'ethnic minority' and 'religion'. Hand searches of grey literature were also conducted using the

keywords identified. However, this did not result in additional papers. Individual organisations were then contacted to source reports about minoritised groups; in particular indigenous and non-indigenous ethnic minorities. From this, seven additional papers and reports were included in the final synthesis.

Optimal mode of delivery for GSMH, online or in-person?

This review also examined the impact of the mode of online vs in-person therapeutic interventions on care. Hand searches were conducted using the same academic databases.

Presentation of data

The results of this review are in two broad sections:

- The narrative synthesis of the research about the experiences of women and girls accessing mental health services. This is divided into three themes: the importance of GSMH, the need for inclusivity for marginalised women and girls, and specific good-practice features.
- The narrative synthesis of findings and good practice, including considerations of the optimal mode of delivery for GSMH services to women and girls.

What is Gender-Sensitive Mental Health?

Gender sensitivity considers the impact of gender on the lived experiences of people. Gender-Sensitive Mental Health (GSMH) is an approach to the design, implementation, and delivery of mental health services through this biocultural perspective. It examines how people of different genders experience and are impacted by the processes, structures, and services they interact with daily. GSMH recognises that the antecedents, presentations, and consequences of poor mental health are highly informed by our own physicality, social context and cultural environments (World Health Organisation, 2011). The root causes of these differences in mental health across genders can vary. They can be physiological for example. How someone reacts to medication can be moderated by gender differences in how the endocrine system operates and how differences in hormone levels impact mental health. For example, oestrogen can be a protective factor which influences dopamine levels, which in turn influences our ability to regulate mood (Lascurain et al., 2020). This can help explain how differences in women's mental health needs change across lifespan and at particular phases such as puberty and menopause. Body image pressures disproportionately affect women, who are more often the target of media campaigns. In 2019 The UK The Mental Health Foundation presented multiple evidence-based findings on the impact of social pressures (including media, family and peers) on the mental health of women, and stated that:

> 'Exposure to idealised bodies in the media (and) social media represents a significant risk of internalising an 'ideal' body image that is unrealistic or unattainable. This social harm has been allowed to develop largely unchecked.' **(The Mental Health Foundation, 2019)P. 5**

The gendered burden of care can also compound and exacerbate mental health needs (Morris, 2001).Patients and clients can also present differently with the same difficulty. For example, the symptoms of heart attack differ across genders, which can have implications for diagnosis. While chest pain is the most common symptom of heart attack, a significantly larger number of women than men do not experience this symptom. Younger women are less likely than older women to have this symptom and mortality rates resulting from heart attack in younger women are higher than men in the same age group (Canto et al., 2012). Neurodiverse boys and girls can have different internal and external experiences. For example, boys with ADHD have more noticeable externalising behaviours than girls with ADHD, while girls tend to have more internalising symptoms, be distracted, or not hold attention (Gershon & Gershon, 2002). In both of these examples of heart attack and ADHD, the differing symptomology for women and girls was identified later than for men and boys, and women and girls still go under-diagnosed (Kim, 2022).

Women and girls attend primary care and mental health services more than men (Department of Health, 2013, 2016). There are differences in mental health presentations across genders too, with women and girls consistently presenting with more anxiety and mood disorders compared to men, and higher levels of PTSD despite experiencing lower levels of what are characterised as traumatising events (Seedat et al., 2009; Tolin & Foa, 2006). Conversely, men and boys present with more externalising disorders, such as conduct disorder, and other behaviours such as alcohol and drug use, and aggressive behaviour, and are more likely to experience traumatising events (Alibudbud, 2022a; Chandra et al., 2019; Seedat et al., 2009; Tolin & Foa, 2006; World Health Organisation, 2011). The nature of traumatising events differs across genders, with men and boys more likely to experience physical assault, fire, non-sexual violence and combat events; while women and girls are more likely to experience childhood sexual abuse and sexual assault (Tolin & Foa, 2006). While Tolin and Foa's quantitative review is compelling a closer inspection of the differences in trauma responses across genders, the reasons for those differences is needed in order to understand how to effectively intervene from a gender-sensitive perspective.

Factors affecting gender differences in mental health needs can be environmental and sociological. The social determinants of mental health include socio-economic status, something which in turn is impacted by gender. Cultural factors must be considered too. For example, poorer mental health outcomes for indigenous ethnic and other minority groups is well documented (Alibudbud, 2022a, 2022b; Bry et al., 2018; McKey et al., 2022; Quirke et al., 2022; Villani & Barry, 2021; Wofford, 2017). Minority stress directly impacts mental health (Bry et al., 2018; Helminen et al, 2022; Kathawalla & Syed, 2019; Pellicane & Ciesla, 2022). Within minoritised groups, gender can impact mental health in subtle ways. For example, women who wear the hijab can experience higher levels of racism than their male counterparts who do not wear religious identifiers (Lindemann, 2021). The Traveller Community as an Irish indigenous ethnic minority has a considerably higher mortality rate than their settled counterparts, and have specific physical health issues unique to their ethnic identity (McKey et al., 2022; Quirke et al., 2022). Nor are these factors discrete, the intersection of multiple factors acting on individuals, or superdiversity as it is known (Vertovec,

2007, 2019), can result in better or poorer outcomes. On average, people from ethnic minority backgrounds from higher socio-economic status backgrounds, have better outcomes than their lower socio-economic counterparts. Similarly, being a person from an ethnic minority and being LGBTQI+ can result in poorer outcomes than for white Irish LGBTQI+ people. GSMH recognises the intersectional nature of the gendered experience.

GSMH also recognises that there are significant disparities in how women and girls are cared for within mental health services, including in relation to medication, diagnoses, and responses to trauma (Chandra et al., 2019). Attitudes of mental health professionals are influenced by their own biases regarding gender which may result in a poorer service for women (Gattino et al., 2020a). There is a strong theoretical underpinning to this perspective in Bronfenbrenner's Bioecological theory of development (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006), and the Social Determinants of Health model (World Health Organization, 2008). These models posit that the health, wellbeing, and development of a person is highly sensitive to environmental, social, and cultural factors, and that these differences persist throughout the lifespan. The trajectory of mental health for a person is influenced by age, as life stage is also a social determinant. As previously discussed, for women, changes in hormone levels across lifespan can affect mental wellbeing (Lascurain et al., 2020). While all of these factors are important to consider, gender remains a critical factor when optimising mental wellness for people including women and girls, trans and non-binary people, and men and boys. Within the context of GSMH, this means that women and girls experience unique mental health risks, challenges, and vulnerabilities based on a multitude of biological, societal, cultural, and sociodemographic factors (Chandra et al., 2019; Sorensen, 2000; Women's Health Council, 2007).

Experiences of Women and Girls Accessing Mental Health Services in Recent Literature

Overview

This section of the review examines contemporary literature published in the last five years about the experiences of women and girls accessing mental health services. The review targeted research about best practice. Core themes that emerged from this recent research, in relation to this topic included:

- Gendered differences in needs change across the lifespan
- Intersectionality and social determinants of health moderate the needs of women and girls
- Women and girls who have experienced trauma have different needs to men and boys

Within each theme, important findings are emphasised.

Theme One: Gendered differences in needs change across the lifespan

The review identified a number of articles that discuss the intrinsic link between gender and all facets of mental health and mental health care across the lifespan. One qualitative study found that care providers understood the need for gender-sensitivity in care from the beginning of life and noted the need for more widespread training for other healthcare providers. The authors note that this was essential to ensure that gender-sensitive care was consistent from the earliest point in a girl's care, and to ensure the early identification of issues (Lindsay & Kolne, 2020). However, the study identified a lack of knowledge amongst pediatricians and mental healthcare professionals about what gender-sensitive healthcare is. This applied regardless of the gender of the healthcare professional; the majority were women. Many of the interviewees assumed the main area of consideration was gender identity (i.e., trans and non-binary clients and patients), which is reflected in the findings from the qualitative interviews conducted for the current research. Lindsey and Kolne recommend GSMH training to healthcare professionals in a range of settings, co-created with experts by experience. Early identification is important, as we know that early life experiences of mental health difficulties can persist throughout the lifespan (Skinner et al., 2019). Research on the impact of the COVID-19 pandemic on adolescent psychosocial well-being identified the need for gender to be considered in adolescent care (Wang et al., 2021). The study identified several gendered differences in vulnerability and impact on factors such as mental health, school performance, and physical health, and concluded that at this stage of life, young girls are more likely to experience mental health difficulties than boys of the same age. The authors highlight the need for policy makers and care providers to "pay special attention to gender differences" and early identification when planning and implementing psychosocial and mental health supports for young girls and women.

Two studies identified in the review were concerned with gender differences in later life. One of these studies examined the mental health needs of older adults with arthritis, and found that there were significant gendered differences in the type of care required, self-perceived need of mental health support, and likelihood of access to care (Howren et al., 2020). This study found that men with arthritis were more likely to rate themselves as needing mental health support and recommended identifying barriers to men's help-seeking behaviours, a factor that has been identified in previous literature (Wendt & Shafer, 2015). Furthermore men tended to engage in more risk-taking and drug and alcohol misuse and exhibit aggression and other negative externalizing behaviours as negative coping mechanisms which in turn impacted the wellbeing of other adults and children around them (Call & Shafer, 2015; Wendt & Shafer, 2015). The second study examined attitudes and perceptions of older women military veterans towards mental health services and help-seeking behaviour (Silvestrini et al., 2020). This study found that women who had previously experienced lower rates of gender-sensitivity in primary care were less likely to disclose their own mental health needs or difficulties to healthcare professionals. While the study is a small sample, building on previous research for women in the military in general, (a cohort of women who experience higher rates of intimate partner violence, sexual assault,

and mental health issues than their non-military counterparts), the unique experience of older women is relevant to all women, and observes the institutional sexism still often encountered in certain professions.

Theme Two: Intersectionality and social determinants of health moderate the needs of women and girls

A key theme identified throughout this review was the differences in experiences of women from different socio-cultural and socio-demographic groups. In one systematic review exploring trauma-informed care in outpatient mental health counselling, the authors noted that marginalised voices are often left unheard in research, service design, planning, and delivery. This presents challenges in adequately assessing service barriers for higher need groups (Bendall et al., 2021). While not directly related to the experience of women and girls, this highlights an overall trend within service design and delivery, where social and cultural factors are not taken into consideration.

In 2008 Cairde, in conjunction with DCU conducted a peer-led study on the experiences of migrant people living in 'new communities'. The study identified three main barriers to mental health: structural, institutional, and discriminatory (Lakerman et al., 2008). In 2015, the study also asked people to identify main areas for focus: they identified structural inequalities, increased information about services, and enhanced integration and belongingness as necessary components for effective mental health supports (Lakerman et al., 2008). Cairde conducted a study to identify barriers to effective mental health provision for ethnic minorities in Ireland (Cairde, 2015). The report identified ethnic minority stressors, structural and institutional barriers to accessing care as well as cultural barriers around perceptions of mental healthcare and stigma associated with mental ill-health. The report also highlights the need for representation of ethnic minority people in mental healthcare professions and the inherent barriers to inclusion in those professions (i.e. the cost of many courses for qualification) which prevents inclusion (Cairde, 2015).

AkiDwA is a national network of minority women in Ireland. In 2019 they conducted a qualitative study on the experiences of women and girls with a specific focus on mental health. The study interviewed 40 women from ethnic minority backgrounds living in Ireland:

> The findings reveal that migrant women experienced significant stressors that have serious implications for their mental health and psychological well-being **(AkiDwA, 2020), P5.**

The study showed that, even though women had experienced trauma prior to arriving in Ireland, the current stressors of the realities of being an asylum seeker, feeling powerless, and feelings of loss were the main contributors to mental ill-health. Echoing the findings of the Cairde study, they found that mental health was further impacted by other barriers to accessing support such as cultural beliefs around stigma and mental health, language barriers and inadequate service provision (AkiDwA, 2020). The study also interviewed mental health service providers who identified Direct Provision as primary source of stress.

> 'Some providers revealed within Direct Provision, migrant women become progressively disempowered and depressed, as the system takes away their autonomy and engenders fear and anxiety.' **(AkiDwA, 2020) P 29.**

The study also includes group art therapy sessions as an effective form of psycho-social intervention for certain groups, and this is borne out in other research presented here.

One study examining the experiences of immigrant women accessing perinatal mental healthcare services found they were at much higher risk of experiencing mental health challenges, and faced significant barriers in gaining access to care (O'Mahony & Clark, 2018). These barriers included cultural attitudes, geographic location, socioeconomic disadvantage, and language barriers. The authors highlight the importance of gender-sensitive community-based mental health supports, and caution that these must be designed to be flexible to adapt to the unique needs of marginalised women. A similar study reported similar findings in the experiences of ethnic minority women in perinatal mental health support, and found a number of culturally specific barriers to care (Pilav et al., 2022). These challenges included cultural expectations of them as mothers, previous negative experiences or perceptions of healthcare professionals, and the positive impact of care provider cultural sensitivity. The study emphasizes the need for training in cultural competence (Betancourt et al., 2016; Henderson et al., 2018; Kirmayer, 2012), and the more recent concept of cultural humility as a pathway for breaking down barriers to accessibility for ethnic minoritised groups (Kirmayer, 2012), This training should be co-created by experts by experience.

Finally, one study in the review examined the experiences of trans and gender diverse people in accessing counselling and therapy for transition-related and general mental health needs (Strauss et al., 2021). The study showed that participants accessed these services for a diverse range of reasons. A lack of sensitivity and awareness of gender-specific factors was identified to be a major contributor towards negative experiences of patients, and low ratings of satisfaction and perceived provider support. Clients reported that some healthcare providers acted as gatekeepers to other health services, and had poor understanding of the needs and experiences of gender diverse clients, and in some cases exacerbated mental unwellness, again a finding reflected in the qualitative aspect of this research.[2]

2 While the World Health Organisation's current International Classification of Diseases Manual categorisies gender incongruence as a sexual health issue (not a mental health issue) access to healthcare, including mental healthcare is still gatekept through the Gender Health Service in Ireland and waiting times are approximately nine years at present for access to gender affirming treatments for public patients.

Theme Three: The care needs of trauma-experienced people may differ by gender

The final major theme identified in the review was the importance of a person-centered approach to providing care. Importantly, the need for services to be trauma-informed has been identified alongside GSMH as priorities in the

latest mental health strategy (Department of Health, 2020). Trauma-informed care refers to an approach that recognizes that people who have experienced trauma will have a highly unique and individualized set of needs. They are at particular risk of experiencing distress or further traumatization and exclusion from services and care (Reeves, 2015). One paper outlined the importance of gender-sensitivity in trauma-informed care, by presenting a framework of gender differences in PTSD. Gender motivation theory (Winstok & Weinberg, 2018), posits that differences in needs and outcomes of people with PTSD may be largely driven by social expectations and beliefs that are highly gendered. Dominant cultural attitudes and expectations, and the care needs of people with PTSD will differ between genders. An additional study identified in this review found that experiences of trauma in early life resulted in different mental health needs in later life between genders (Skinner et al., 2019). This is consistent with research cited elsewhere in this report (1.3.1). The relative lack of research conducted specifically on impact of medications and interventions to address the needs of women and girls highlights the necessity for more targeted research on the causes and effective treatment (both pharmacological and therapeutic) with regard to mental health in general (Kim, 2022; Lascurain et al., 2020).

A further study on this theme examined the experiences of healthcare professionals who work with women and girls who have experienced sexual violence, and noted that gender-sensitivity is a core component of a successful approach (O'Dwyer et al., 2019). A study which focused on the experiences of young mothers found that hesitancy to seek care was caused by previous negative experiences with providers (Jack et al., 2022). The authors highlight the need for gender-sensitivity and attribute a lack of gender-sensitivity as a potential underlying reason for many of these experiences. Overall, it is evident that gender-sensitivity principles are a fundamental and necessary part of trauma-informed care, and are associated with better clinical outcomes (Lovell et al., 2022), and more effective relationships between patient and provider (Than et al., 2020).

Summary

The unique determining factors and presentations in relation to mental health from a gendered perspective are well-established in literature. This section highlights findings emerging in the literature over the last five years, and documents core themes including the importance of gender sensitivity across the lifetime from early intervention through to elder years, the literature consolidating what is well-established in relation to the experiences of women and girls from minoritised groups, and the importance of gender-sensitivity in establishing trauma-informed services.

Good Practice in Gender-Sensitive Mental Health

Overview

This section details findings from the systematic searches and hand searches in relation to good practice in Gender-Sensitive Mental Health (GSMH). Three core themes emerged in relation to good practice:

1. The case for GSMH. This theme includes findings about the impact of GSMH on the efficacy of mental health interventions, the lack of GSMH in many jurisdictions, and how experiences or lack of experiences of gender-sensitivity in care can impact future use of services.
2. Inclusion of marginalised women and girls. This theme describes the ways in which women and girls from already marginalised or minoritised backgrounds experience significant and unique challenges in the types of care needed, ability to access care, and how services may endeavor to mitigate these difficulties.
3. Specific good-practice considerations. The final theme explores considerations in relation to the mode of service deliver through a gendered lens, primarily considering the case for online and in-person delivery modes.

Theme One: The case for Gender-Sensitive Mental Health

Overview

This section presents literature that details the absence of GSMH, as well as the strong case for services that incorporate GSMH, arising from a positive correlation between working in this way and service user engagement and outcomes.

There is a lack of gender sensitivity among medical doctors and mental health professionals

The narrative synthesis indicates that, where research has been undertaken, there is a lack of gender sensitivity (GS) in primary care, mental health services, and among the healthcare professionals who work in them. In consideration of mental health specific services, a study examining the perceptions and evaluations of mental health professionals found that a majority felt the profession was not adequately gender-sensitive in how care was delivered (O'Dwyer et al., 2019). One of the key recommendations the professionals provided was that all mental health professionals should be challenged to consider how they are providing gender-sensitivity in their care delivery, and how this may impact on the engagement of women and girls in need of support.

A commonly observed challenge in mainstreaming GSMH included a lack of training or professional awareness. One study on this theme found that while female doctors are more likely to practice GS principles than male ones, a stronger predictor of gender sensitivity in family medicine is how recently a doctor had completed training. In a gender-balanced sample of Italian physicians N=431 gender sensitivity of practitioners was compared with levels of sexism across a

number of scales. The study found that women are more gender-sensitive, and years of service also affects gender sensitivity; newer trainees scoring lower on gender-stereotyping scales and sexism than men (Gattino et al., 2020b).

The findings from this section indicate that gender-sensitivity needs to be carefully considered at undergraduate level training, as well as embedded in core service provision by more seasoned professionals.

Mental health interventions are more effective when gender-sensitive

The papers in this review highlight a clear relationship between gender-sensitivity and the efficacy of mental health interventions and treatments. Studies show that an individual's psychological capability, motivation, and self-efficacy are highly sensitive to their cultural and social environment, and interventions greatly benefit from an individual, person-led, and gender-sensitive approach (Dieleman et al., 2021; Jacobs, 2019; Orshak et al., 2022). In one large scale study, researchers investigated what intervention components were associated with better mental health outcomes in community health workers from low and middle income countries (India, Kenya, Peru, Bangladesh, Ethiopia, Nepal, the Philippines, and South Africa) (Yakubu et al., 2022). Gender-sensitivity was found to be a critical components, and one that the authors describe as "necessary for successful intervention."

In terms of the quality of care, as reported by patients, gender-sensitive care is associated with more positive reports of care (Chanfreau-Coffinier et al., 2019), as well as quality of the relationship between patient and provider (Knight et al., 2018). In these two studies, qualitative interviews were conducted with patients and providers respectively, and independently explored how positive experiences of gender sensitivity improved these experiences. Another study surveyed 73 experts in women's mental health, and among other findings, discussed how low gender sensitivity is associated with poorer mental health outcomes and lower ratings of satisfaction of treatment (Chandra et al., 2019).

A number of identified studies test the efficacy of different approaches to delivering mental health support (Jalisi et al., 2018; Kaplan, 2021; Mannell et al., 2018; Poudel-Tandukar et al., 2019). One paper explored the concept of "feminist therapy" as an alternative method of providing gender-sensitive mental health support incorporating psychosocial, psychological and psychiatric support (Kaplan, 2021). This is a therapeutic approach that incorporates elements of gender sensitivity in tandem with a strengths-based approach to treating issues such as depression, anxiety, and low mood. As the authors note

> "The biomedical model and mainstream therapy approaches applied as a treatment for mental problems of the women are especially inadequate for producing permanent solutions for the problems experienced by women" **(Kaplan, 2021, p.211).**

The authors criticise mainstream approaches to mental health, support for women and girls which focus on medicinal intervention, without suitable psycho-social support.

Mannell et al. explored how alternative methods of therapy are useful, particularly

in relation to gendered mental health needs (Mannell et al., 2018). This study found that for survivors of gender-based violence, alternative therapies, such as narrative storytelling, may be an effective type of support for women. Similarly, a study examining support groups for mental health of ethnic minority women found that their bilingual support group was of particular help, and that women were more likely to remain in this therapy than men (Jalisi et al., 2018). Further studies examining the ways in which mental health support can be made more culturally accessible and more gender-sensitive note that novel community-based approaches, which include the wider family, can be an effective means of caring for refugee women (Poudel-Tandukar et al., 2019). These findings suggest that a broader view of what constitutes the provision of mental health supports should be taken. These findings suggest that there are several factors that determine how a patient will access, experience, and perceive care, and a gender-sensitive approach is critical in ensuring adequate care is provided.

Summary

This section shows low levels of GSMH, and affirms the importance of it by highlighting evidence indicating improved outcomes where it is present, and details specific practices both in terms of professional training, and intervention models, that should be considered for improving GSMH.

Theme Two: Inclusion of marginalised women and girls

Overview

This section describes literature that highlights findings in relation to the experiences of women and girls from minoritised communities, focusing on how they are disproportionately at risk of exclusion or disengagement from services compared to their counterparts from dominant communities. The literature provides guidance and recommendations on how services can be aware of intersectional needs and good practice to include and engage these communities.

The barriers experienced by women and girls from minoritised communities must be considered in the provision of gender-sensitive mental health care

Ensuring equitable access to health care for women and girls from minoritised or marginalised communities is a health promotion challenge (Mahler, 1981; World Health Organisation, 2011). Here, access refers to the ability to seek care when it is needed, as well as the types of health care accessible, the quality of the care provided, the financial and personal cost of seeking the care, and the level of general knowledge a person holds about their own health needs (Kirmayer, 2012).

One of the most concerning areas of health disparity for marginalised people is in the quality of, and access to primary care services (Corscadden et al., 2018). While there has been limited studies conducted within an Irish context, there is a body of evidence gained from studies within the United States and United Kingdom to demonstrate this disparity (Silberholz et al., 2017). It has been observed that areas with a larger proportion of minority population are less likely to have access to integrated care services, including primary care facilities, and experience less

comprehensive and lower quality service overall (Guerrero & Kao, 2013). This indicates there is a structural element to this disparity, in that the design and delivery of services provided is less adequate in areas of minority populations. Within the United States, areas with a larger proportion of non-white residents are less likely to have access to behavioural health services through primary care and/or community settings (VanderWielen et al., 2015). In addition, these disparities persist beyond primary care, and impact on critical access to mental health support services mental health (Yucel et al., 2020), maternal and post-natal health (Essien et al., 2019), and child and infant neurodevelopmental supports (Dababnah et al., 2018).

In consideration of how these challenges may be addressed, research and practice has been successful in reducing disparity, by action such as educating healthcare providers on cultural norms and values, improving means of communication between provider and patient, and the inclusion of community members in health provision (Betancourt et al., 2016; Capell et al., 2007; Henderson et al., 2018). Overall, cultural competence training and practices within health services have found that when implemented, consistent increases in minority patient satisfaction and outcomes are the result (Alizadeh & Chavan, 2016a; Govere & Govere, 2016a). There is strong evidence to suggest that implementing cultural appreciation and/or sensitivity within care settings has significant benefits for patients from cultural and ethnic minority backgrounds. And this is of particular salience when considering how mental health support can be delivered in a gender-sensitive way (Than et al., 2020; Women's Health Council, 2007). These findings are particularly relevant for women of migrant background and of Traveller or Roma heritage, so that they may have optimal experiences of mental health support services in Ireland.

Inclusivity of marginalised women and girls requires heightened flexibility by service providers

A scoping review investigating this topic noted the poor prevalence of gender sensitivity in health settings and research, and noted that an intersectional approach is critical in mainstreaming GSMH (Mena et al., 2019). The authors note there is a need for providers to recognize the unique challenges and needs of women and girls from marginalised backgrounds and identities. This topic was studied in another identified paper, which noted the importance of gender sensitivity, as discrimination and negative experiences from providers can detrimentally impact on future mental health care access (Tanner, 2019). Migrant women are less likely to access mental health care in Ireland and are more likely to have a negative experience when they do (Murphy, R et al., 2021). Furthermore, gender differences in relation to quality of care are also exacerbated by other marginalised identity group memberships, such as belonging to a minority including but not limited to disability, LGBTQ+, ethnic minorities and potentially social class (Mena et al., 2019).

Several papers identified in this literature review highlighted that GSMH requires intensified flexibility in order to meet the unique needs of women and girls (Alibudbud, 2022a; Crane et al., 2019; Kahn et al., 2018). This is particularly true when considering issues of accessibility for particular marginalised communities, for example women from The Traveller Community, women who use drugs,

women experiencing homelessness, care-experienced young women and disabled women, amongst others. Services are often experienced as inaccessible to those outside of the dominant social group. For example, one study examined the general experiences of young autistic adults within mental health settings (Crane et al., 2019). In addition to finding that autistic adults faced severe difficulties in accessing required mental health support, autistic women in particular were found to experience elevated levels of challenges, especially when accessing support. Another study sought to examine the mental health support experiences of gender diverse and LBT women who were forced migrants, found that the population experienced a significant amount of difficulty in accessing care due to both internal and external factors (Kahn et al., 2018). A third study examined the rate of depression and anxiety among young women in the Philippines, finding that sexual minority women were at higher risk of experiencing these issues than heterosexual counterparts (Alibudbud, 2022a). The authors of this research conclude that there is a need for a "gender-responsive" approach to care to address the issue. By this, the authors refer to an approach that can address the heightened disparity and risks associated with mental health in women who are from already marginalised backgrounds.

Exclusion and marginalisation can also be viewed in relation to high rates of social stigma. A study conducted in Ireland in 2008 mapping the needs of ethnic minorities noted that participants did not discuss their mental health needs in the study (Lakeman, R et al., 2008). However, the study does note that mental health supports go beyond therapeutic intervention and should include social determinants such as adequate housing and building social capital in minoritised communities. For example, a study on the experiences of asylum seeker, refugee and right-to-remain women conducted in Ireland highlights the cultural differences in construction of mental ill health. Being a woman and a forced-migrant was predictive of poorer mental health than being a man and a forced-migrant. Stigma and taboo were common themes for participants and blame for poor quality of relationships (i.e. marriage) often lay with women (AkiDwA, 2020). These findings bolster a previous Irish study which, along with identifying shame and stigma as barriers to seeking supports identifies cultural differences in the construction of domestic violence as being the 'fault' of the women (Bojarczuk, S et al., 2015).

The disparity in mental health between the settled community and our indigenous Traveller Community was first highlighted in The All Ireland Traveller Health Survey (Department of Health, 2010) and is well documented (Department of Health, 2022) but actual research is sparse (McGorrian et al., 2012; McKey et al., 2022). Nonetheless there are stark disparities between the mental health of the Traveller Community and the settled community in Ireland. For example (Quirke et al., 2022) found that discrimination presented a barrier to Travellers accessing mental health services. The authors recommend an improvement in cultural competency in healthcare staff with regard to that population. Another recent study conducted with members of the Traveller Community highlights the need, once again, to address inequalities in the social determinants of health and a recognition of the unique cultural needs of the Traveller Community (Villani & Barry, 2021). While stigma and shame regarding mental health were

factors identified in the study, discrimination and racism was also highlighted with the recommendation to focus on the reduction of discrimination. The study also suggests a strengths-based approach to the reduction of mental ill health by enhancing Traveller pride and the promotion of Traveller culture.

A paper examining the experiences of people in the street-based commercial sex trade accessing mental health care (Potter et al., 2022), found that in the majority of cases mainstream mental health services were inaccessible, and that trauma-informed, gender-sensitive, community-based support in health services is an essential step in ensuring these needs are not left unmet. While there were many reasons stated for this inaccessibility, among the most significant were experiences of stigma and discrimination, lack of gender sensitivity in services, lack of trauma-informed approaches, and non-flexible appointment hours.

A final study examined the ways in which mental health services can be developed and promoted in a multicultural way, noting that "mainstream mental health promotion must be complemented by activities that target specific population groups" (Blignault et al., 2022). For example, within this study, a mindfulness based mental health intervention was used to promote the mental health and wellbeing of migrant communities. The authors found that factors such as the language of the intervention delivery, the capacity to adapt the intervention on a needs-led basis, and developing community partnerships were highly successful in promoting overall well-being of the sample. This highlights the need for services to be capable of delivering a certain level of flexibility in order to meet the needs of further marginalised women and girls.

Summary

A strong theme emerging from the literature on good practice in GSMH is the importance of intersectional experiences being considered in relation to the design of effective GSMH. The literature clearly highlights that there is no one-size-fits-all treatment for all women and girls, and that the lens of gender must be considered alongside other socio-economic and socio-cultural factors if it is truly to have its intended impact for all women and girls.

Theme Three: Optimal Mode of Delivery for Gender-Sensitive Mental Health, online or in person?

A significant challenge in ensuring that mental health support is gender-sensitive, is ensuring accessibility in how therapeutic supports are provided to patients. This issue has taken on increased relevance since the beginning of the COVID-19 pandemic; since 2020 there has been a significant increase in the number of mental health supports that are provided by telephone or online (Humer & Probst, 2020). This change can also be viewed against a backdrop of growing acceptance among professionals that therapy moving from in-person to online was a generally positive experience for many, with many providers intending to continue providing an online option for supports even after health restrictions were lifted (Békés & Aafjes-van Doorn, 2020). In particular, an online option can support access for women in the disabled community, and those who can find in-person appointments more challenging to attend. While online therapy has come

to the forefront of discussions around service delivery, the efficacy and utility of online and telephone-based delivery has been studied for many years. There is an abundance of research examining the efficacy of specific types of therapies, which has found, in relation to therapeutic outcomes:

- A systematic review of 10 empirical studies found that online Acceptance and Commitment therapy may be effective in use for depression (Brown et al., 2016).
- Promising results in the delivery of online eye-movement desensitization and reprocessing therapy (EMDR) vs cognitive behavioural therapy for the treatment of PTSD (Perri et al., 2021). This relatively small trial of 38 participants suggests that online delivery may be an effective means of remote PTSD treatment, and merits further study. The HSE, for example offer CBT and EMDR for people with PTSD in community-based settings. Intervention may involve a mixture of prescribed medication and talk therapy. For girls and boys trauma-focused CBT is the default intervention for PTSD who access services through the HSE.
- A meta-analysis of 47 studies testing the efficacy of in-person vs online therapy found no clinical difference in cognitive behavioural therapy outcomes for affective disorders e.g. anxiety and depression (Fernandez et al., 2021). However, the authors note this effect is likely affected by publication bias.
- A systematic review of 41 studies examining the effectiveness and utility of remote dialectical behavioural therapy found mixed results (van Leeuwen et al., 2021). The authors of this study state that a permanent move towards online delivery is not recommended where in-person delivery is possible.

However, while there is limited research examining the impact of gender within the context of therapy delivery, there is reasonable evidence to suggest that there should be caution in how services are provided (Black & Gringart, 2019; Budge & Moradi, 2018; Dale et al., 2021; Honey et al., 2021; van Leeuwen et al., 2021). For instance, it is known that gender can have a significant impact on a person's experiences of therapy, how amenable they are to it, and how accessible they perceive it to be (Black & Gringart, 2019; Budge & Moradi, 2018). It is also known that both accessibility and efficacy of online therapy and telehealth is highly influenced by factors such as access to the correct technology and the level of comfort and confidence in using them (Honey et al., 2021). Finally, there are several gendered social risk factors that influence ability to access services, including; women being more likely to be unemployed than men, being more likely to have additional care responsibilities, and being at higher risk of experiencing domestic violence in the home (Dale et al., 2021). These additional gender-based challenges mean that women and girls are at elevated risk of not only experiencing difficulties related to mental health, but also find it harder to access care. Despite this disparity, there is yet no conclusive research on whether online or in-person is preferable, and the efficacy and accessibility will vary between communities and individuals.

Online therapy and telehealth can be an effective tool within the provision of mental health support services. However, it does not come without limitations. Within the context of primary care and community-based support, it has been

noted that there is insufficient research which has examined how remote delivery can be integrated to existing delivery, and some experts have cautioned that existing community support structures such as primary care, timely intervention systems, and access to specialist support should be bolstered before relying on remote mental health support delivery (Mughal et al., 2021). What is understood is that best-practice in the delivery of gender-sensitive mental health requires there to be a person-centred approach (Kaplan, 2021; Rodgers et al., 2021), and that the mode of delivery must be led by the patient's needs and preferences where possible.

Summary and Good Practice

This review identified five key themes related to the low prevalence of gender sensitivity, the effectiveness of gender-sensitive principles in practice, and how the needs of women and girls are highly sensitive to context and require person-centered approaches and flexibility in delivery to facilitate accessibility and success. The findings are consistent with policies outlined in this review. Based on these findings, and from previous research and recommendations (Gagliardi et al., 2019; National Women's Council, 2018, 2020; Women's Health Council, 2007), the following key features were identified as core to good practice in the development and delivery of gender-sensitive mental health care:

Theme	Good Practice
The need for gender-sensitive interventions	• A range of different therapeutic options need to be available to ensure a person-centered approach to care (Black & Gringart, 2019; Kaplan, 2021; Mannell et al., 2018; Yakubu et al., 2022) • Mental health supports require a strengths-based approach (Kaplan, 2021) • Remote types of therapy should be made available as an option, but not as a replacement for community-based support (Mughal et al., 2021)
Lack of gender sensitivity among professionals	• Professionals should be trained in gender-sensitive care (Gattino et al., 2020b; National Women's Council, 2021; O'Dwyer et al., 2019; Sen, 2007; Sen & Östlin, 2008; Women's Health Council, 2007) • Professionals should have training in recognizing their own bias regarding gender(Andersson et al., 2012; Gattino et al., 2020a) • There needs to be systems to monitor data related to mental health access and needs for women and girls (National Women's Council, 2021; Women's Health Council, 2007)

Theme	Good Practice
Core component of trauma-informed care	• Gender sensitivity is an essential component in providing trauma informed care to women and girls (O'Dwyer et al., 2019) • There is a need for professionals to have an awareness of the ways in which trauma impacts people differently by gender, and how this persists throughout the lifespan (Jack et al., 2022; National Women's Council, 2020; Skinner et al., 2019; Winstok & Weinberg, 2018). The variation in presentation and coping mechanisms with regard to trauma across genders warrants further consideration.
Flexibility in approach, especially with those from marginalised backgrounds	• Supports should be made available within community settings, and outside typical hours (Mughal et al., 2021; National Women's Council, 2021; O'Mahony & Clark, 2018; Potter et al., 2022) • There should be an explicit inclusion of marginalised people within the service planning design and delivery (Bendall et al., 2021; Department of Health, 2020; National Women's Council, 2020; O'Mahony & Clark, 2018; Potter et al., 2022; Women's Health Council, 2007) • Services need to be able to mitigate gender-specific barriers to care, including: rates of employment, care responsibilities, and domestic violence (Dale et al., 2021; National Women's Council, 2021; Women's Health Council, 2007) by offering: – Timely, free, and flexible therapy to women and girls – Culturally aware therapeutic interventions – Providing wrap-around supports for carers of children and older adults • Professionals should be trained in cultural competency and cultural humility, which has gender sensitivity integrated into it (Alizadeh & Chavan, 2016b; Govere & Govere, 2016b; Khan, 2021). This training should be tailored to increase awareness of the specific needs of the Traveler Community, of asylum seekers and refugees and specific ethnicities and groups including, but not limited to, peoples from African countries, Central and Eastern Europe (including Ukraine) and Muslim communities. While not originally designed for non-ethnic minorities training should also consider gender-diverse identities and their specific needs

Theme	Good Practice
Accounting for gendered differences across the lifespan	• Gender sensitivity is required at all stages of the life span, from birth through adolescence, midlife and menopause (Hogervorst et al., 2022; Timur & Sahin, 2010) and older adulthood (Fawcett & Reynolds, 2010) and has specific interventions and nuances at each life stage, from perinatal care (Pilav et al., 2022), early life (Wang et al., 2021), childhood and adolescence (Department of Health, 2016), and older adulthood (Howren et al., 2020; Silvestrini et al., 2020). This should be highlighted through: – Design and delivery of GSMH training programs on differences across lifespan for current practitioners (GPs, mental health professionals) using a biopsychosocial approach – Design and delivery of a module on differences across lifespan from a GS perspective for students in medical, nursing, counselling, and psychotherapy courses – Integration of GS into all other aspects of physical and mental healthcare programs e.g., pre- and post-natal care, care across lifespan (menopause and older adult care) • Systems need to be in place within primary care for the early identification of mental health needs in early life, particularly school age years (Department of Health, 2020, 2021, 2016; Women's Health Council, 2007).

5. Qualitative Interviews and Focus Groups

Overview

The aims of the qualitative aspect of this research were to:

- Map current awareness of GSMH in the HSE mental health services, for general practitioners and third sector organisations providing or directly referring to mental health services.
- Capture the current level of GSMH practices being implemented 'on the ground' from the perspective of frontline practitioners and identify gaps in understanding and practice.
- By engaging with practitioners and organisations providing mental health services and referral to mental health services to specific cohorts of women, identify the specific needs of women from an intersectional perspective.
- Identify achievable and practical GSMH interventions and strategies for implementation.

Methodology

There were two phases to the qualitative aspect of this study:

- Interviews were conducted with senior leaders and relevant stakeholders from the HSE and relevant third sector organisations, representatives from the medical professional organisations, diverse counselling or primary care services or *Sharing the Vision* Policy Managers (n=11).
- Four focus groups were conducted with frontline practitioners involved in the provision of mental health services to people with mild to moderate mental health issues and organisations providing mental health referrals for specific minoritised women. There was representation from a diverse range of organisations serving a wide range of women and girls (see more detail below) (n=21).

Participants

The target groups for the interview phase were:

- Policy makers and managers of mental health services involved in the delivery and development of mental health policy for implementation in the HSE.
- Third sector organisations who are directly involved in or have clear referral pathways to mental health services.
- Representatives affiliated to professional bodies advocating for the provision of mental health services including medical practitioners and mental health specialists.

They were identified and recruited through relevant gatekeepers and stakeholders with the support of the advisory panel.

Participants for focus groups were recruited through HSE and third sector contacts of relevant organisations. There were contributions from organisations serving

women from the Traveller and Roma communities, women who are homeless, women with addiction issues, women from low socio-economic areas, women in transient accommodation including hostels, refuges and Direct Provision, women from Muslim communities, women who are trans, women from rural communities, women who are seeking international protection including asylum seekers, refugees and women fleeing war, ethnic minority women, young women, perinatal women, women experiencing menopause and women experiencing domestic violence. Of the 21 participants in the focus groups nine worked directly for the HSE.

Nonetheless, a limitation of this part of the report is that despite best efforts to capture the broad range of women's experiences, some voices may be underrepresented, for example women with disabilities, women who are trafficked, women in the commercial sex trade and women who are LGBQ+.

The interview schedule

A semi-structured interview schedule for both phases was developed based on the findings from the literature review and in consultation with the advisory group. The schedule was structured as follows:

1. A general question in terms of what contributors understand GSMH to be.
2. Their assessment as to the extent they considered their service to be gender-sensitive, giving examples where possible.
3. Their understanding of the factors impacting women's mental health and barriers to accessing mental health services.
4. Suggestions for the improvement of GSMH practices in contributors' service or in general, and an opportunity to shared effective practices that could be transferred to other environments or scaled-up.
5. Questions relating to whether specific good practices, as identified in the literature review were implemented in the service.

Interviews were conducted online and lasted between 40 minutes and an hour on average while focus group session averaged two hours in duration.

Analysis

Interview and focus group transcripts were analysed using thematic analysis (Braun & Clarke, 2012; Clarke & Braun, 2017). While some themes were prescribed and therefore form the first three themes of the results from this process, open question phrases were sorted using a method of constant comparison and on completion of this process themes emerging from the data were identified and named based on their content(Glaser & Strauss, 2017).

Key Findings from Expert Interviews

Introduction

The semi-structured interview included some set questions grounded in the findings from the literature review, for example in relation to knowledge of GSMH and modes of service delivery. For this reason, all of these themes were addressed by contributors to the qualitative aspect of this report. Other questions were open, allowing participants to raise the salient issues from their perspective, about provision of services in Ireland and within their organisation. Given the heterogeneity of contributors, some issues raised are specific to a particular cohort of women served, but that does not imply other interviewees did not also agree with the point; nor that it is less important than other issues raised. It simply may not have been discussed. Overall, nineteen themes emerged from the thematic analysis. These are presented below in order of frequency.

- Self-assessed practitioners' knowledge of gender-sensitive mental health varies widely among professionals
- A gendered lens is absent from policy and strategy
- Need for choice and flexibility, particularly for online and in-person therapeutic supports
- A lack of housing and income have an outsize effect on women's access to mental health care
- A two-tiered, overburdened health system results in marginalised groups not getting required services
- Domestic and intimate partner violence have a serious impact on women and girls' mental health
- Addiction frequently deprioritises women's mental health
- The need for additional cultural diversity and cultural humility
- Women seeking international protection have a complexity of needs
- Pathways to care for women who are trans need to be improved
- Lack of childcare is a significant barrier to accessing services
- Menopause is not given sufficient consideration in policy or practice
- Stigma and shame present powerful internal barriers to accessing mental health care
- Social prescribing and other proven early intervention and prevention strategies require more resourcing
- Addressing gender bias and unconscious bias in the delivery of healthcare
- People living in rural areas have disproportionate barriers to accessing services
- Isolation and combined physical and mental health needs have a significant impact on older women's mental health
- Social media can be a protective or risk factor
- Perinatal mental health needs to be further understood and supports provided for specific groups of women

1: Self-assessed practitioners' knowledge of gender-sensitive mental health varies widely among professionals

Stakeholder interviews

> As a mental health professional, there's so much evidence regarding mental health and gender [and] women, it's something we can't ignore and that goes for other minority women. Particularly intersectionality, women who are trans, women of colour, lesbian women of colour... It's our job to educate ourselves, we can't be passive; we have to be active and proactive. And if we don't, we'll be irrelevant. **Interviewee 11 (C&VS)**

Self-reported levels of knowledge about gender-sensitive mental health varied widely across stakeholders. Responses to the question "What you understand the meaning of 'gender-sensitive mental health' to be?" ranged from practitioners stating that they did not know anything to assessing themselves as having a very firm grasp of the concept and how practices could be implemented. Overall knowledge about what being gender-sensitive entailed was rated as slightly higher in other third sector organisations than the HSE or medical profession. An understanding of what the term gender-sensitive means was lowest among medical practitioners. Two interviewees did not know what it meant and overall, the terminology was not familiar to five of the contributors. However, all were aware of the general need to be supporting women's health, and understand this within the context of gender. Interviewees were also aware of the barriers for women in accessing mental health services from a gendered perspective. Five of the eleven interviewees thought gender sensitivity referred primarily to being aware of gender variance, trans or LGBQI+ people and their needs.

> It's about being sensitive to the particular issues re: gender. Men, women, non- binary in that particular context e.g., use of language for gender-diverse people. If a person is trans... communication. **Interviewee 2 (HSE)**

However, while some contributors firstly emphasised trans and gender variant identities as being core to this approach, they also had a wider understanding of the concept on further discussion:

> There's a lot of theory but it's linked to the social determinants of ill health. Discrimination, unfair inequality, toxic engagements usually with men. It creates the scenario of women who present with higher levels of self-harm. Access to housing, independence, and inequality in work. Women have a series of different health concerns: child rearing, menopause, gender-specific health concerns. **Interviewee 2 (HSE)**

Interviewees who had a very low level of knowledge about GSMH were eager to learn more, and made concrete recommendations for increasing awareness of gender sensitivity including the delivery of seminars to medical professionals in

practice (deemed to be more effective than written material) and the integration of gender-sensitive material in undergraduate courses. These findings suggest that a general lack of awareness is due to the invisibility of, or lack of discussion around gender sensitivity in medical and mental health settings in Ireland.

Focus groups

Frontline practitioners tended to have a clear understanding of the concept while, once again, the actual phrasing is little used. Frontline practitioners were also likely to go into more detail about how intersectional factors disproportionately impacted the mental health of women and give concrete example from their own service or practice:

> That term is not a term used in mental health services but to consider social, political influences on a woman or a man, obviously be sensitive to that. So, if you're looking at mental health for women at particular periods of life, including menopause pregnancy perinatal and domestic violence. **FG3**

The majority of contributors discussed specific aspects of gender-sensitive theory and practice. There were graduated levels of knowledge which ranged from using appropriate terminology and respecting clients gender variance or sexual orientation to a more granular understandings of how social determinants of health and intersectionality impact different genders differently (further discussed in specific themes below).

2. A gendered lens is absent from policy and strategy

Stakeholder interviews

While a strong majority of contributors had some understanding of gender-sensitive practices, there was a disparity between their level of knowledge and what was actually being implemented in their service. The majority of organisations supported all genders but felt their organisation was not specifically gender-sensitive in the way the service was provided. For these services there was one approach or way of working for all genders, and specific gendered needs were not enshrined in policies or working practices. However, there was some progress being made, some organisations, namely those who provided services to vulnerable groups (for example people with addiction, people who are homeless and people experiencing isolation in rural areas) had just begun initiatives that were specific to the needs of women.

A majority theme is that women's Issues are not sufficiently considered within existing mental health policy and strategy landscape. It was highlighted by three interviewees working within HSE services, that women's issues are underrepresented in both Connecting for Life and *Sharing the Vision*.

This issue was viewed as being linked to the fact that women are often not adequately represented at decision making tables, and a perceived 'invisibility of women in policy', in particular it was noted, women's specific needs are not sufficiently addressed in *Sharing the Vision*. The lack of representation of women at policy level on mental health was also considered a related barrier to gender sensitivity in policy and services.

One interviewee also noted that gender bias was present in foundational resources in mental health, such as the DSM V-TR, and that this was likely to translate to a subtle bias in practice:

> I think it's also important to consider the biases in the diagnostic manuals used e.g. DSM V. Significant gender (and other) bias has been shown in diagnostic development and practice. **Interviewee 11 (C&VS)**

The need for advocacy to increase the focus of GSMH with a focus on women and girls was viewed as a necessary response. One of the main barriers to implementation of more GSMH practices highlighted by HSE interviewees in particular was a lack of overarching policies or strategies that enshrine a gender-sensitive focus. While most services identified that the needs of minoritised groups were important and considered in service design, the overlay of a gender-sensitive lens was lacking:

> We're not gender-sensitive at all. We do sometimes identify priority groups. I don't think a gender lens is used… There isn't a strong consideration of gender at all for policy. **Interviewee 2 (HSE)**

For community and voluntary services there was a similar gap between the knowledge of the interviewee and what was happening in their service in practice.

> No. I don't see it happening anywhere, very little. For example, trying to get free period products into services, people who may not have the finances. These are important signifiers. There's a lot of talk of menopause (but no actions to support menopausal women)… childcare is an issue but we don't provide childcare. **Interviewee 11 (C&VS)**

Nonetheless, the majority of interviewees were strongly supportive of the need for more gender-sensitive approaches to the provision of mental health services to women in particular. The below quote from a HSE interviewee echoes the views of the majority of contributors regardless of the organisation they worked for:

> It matters because the experiences we have are key for mental health outcomes, which are closely related to gender… It comes down to having more focus on a person's living circumstances rather than just the issue that the person presents with: [what does it mean for them to be a] young girl, older man, say? **Interviewee 3 (HSE)**

Focus groups

One of the main barriers to implementation across HSE and community and voluntary services, was the lack of frameworks for assessing need based on gender and other intersectional factors. A lack of system and service level data collection for demographic need and outcome data was identified. Without data on needs or service gaps and also outcomes or progress, knowing where to implement new practices and evaluate them is extremely difficult. The challenge was raised that services which focused on a particular target group were unlikely to gather data on other aspects of a person's experience or identity.

While frontline workers in services part-funded by the HSE had specific reporting responsibilities which included a breakdown of people using their service, there was a lack of clarity about whether that data was consistent across all services. It was also not clear how this data affected service planning. There was a lost

opportunity to provide consistent data to target the needs of specific cohorts of women and girls, for example people experiencing isolation in specific rural areas. This lack of clarity, coupled with the lack of gender as a specified area for interest in government policy, means that service providers cannot access funding for gender-sensitive interventions and practices.

All interviewees agreed that gender sensitivity was not a factor in the design and delivery of services currently.

> It would be helpful to have a policy that is gender-sensitive, men, women and across lifespan. If there was demand on us to have that we may change how we do things, we're just generic. **FG 3**

3. Need for choice and flexibility, particularly for online and in-person therapeutic supports

Stakeholder interviews

All interviewees were asked about their views on the benefits or disadvantages of in-person as compared to online mental health supports. The value of having the option to select online supports, was unanimously highlighted. An interviewee emphasised this need for access via various mediums, and that offering online services was key, even though it was not the most popular choice:

> We measure engagement, we do see a difference here. The main preference is face to face, then video and then phone. **Interviewee 7 (Private provider)**

A minority of stakeholder interviewees advocated for the use of SilverCloud, an online CBT driven, mental health support service. SilverCloud works on two levels, unaided and aided supports. Unaided supports consist of the client engaging in an online course while aided supports give people limited online access to a coach. Contributors reported low uptake of the unaided support option in particular and felt engagement with the portal was more effective when personal supports were provided. One interviewee highlighted (by their understanding) the lack of independent data on the efficacy of these types of supports and a lack of data on attrition levels from programs. A majority of interviewees highlighted the difference between providing online one-to-one therapeutic supports via Zoom for example and supports provided by companies contracted to provide online toolkits and interactive supports to people. However, it was also highlighted that a recent meta-analysis of the effectiveness of internet-based supports such as those provided by SilverCloud found that such supports were effective in the treatment of anxiety and depression. This study found no difference between the type of supports (iCBT) compared to other therapeutic modalities delivered in this way. The study did not examine attrition, an important factor to consider. The authors of that paper also highlight that while findings suggest that online supports are effective, the wide range in variance in efficacy from one individual to another suggests it may not be effective for everyone. The study intended to examine if the level of personal support provided was a factor in the efficacy of intervention. However this was not possible to ascertain as there

were not enough studies that did not provide personalised support for comparison with those that did (which comprised the majority of studies in the analysis) (Eilert et al., 2021).

A majority of contributors emphasised the difficulties specific groups of women had using an online service of any kind, including women experiencing domestic violence, women who are homeless, older women, women in Direct Provision and women caring for children in the home.

> To access online mental health supports you need access to a safe private space; intimate partner violence, temporary accommodation [make this hard]. The same applies to Direct Provision. **Interviewee 4 (Professional advocacy group)**

Focus groups

The majority of focus group interviewees reported observing no difference in the effectiveness of online versus in-person one-to-one support. A number had examined the efficacy of online compared with in-person supports with their clientele and found no difference between the two modes of delivery. A minority disagreed with this assessment, preferring in-person supports to online modes of delivery. Nonetheless, all interviewees were careful to emphasise that in certain specific circumstances one was more suitable than the other. For example, for many, in-person was preferable for initial sessions with clients, particularly those with moderate mental health difficulties as compared to mild. The overarching theme from all interviewees was the need to offer flexibility and choice, that without that choice certain specific cohorts of women who needed support would not be served. Contributors pointed to the need to tailor accessibility depending on individual circumstances, some of which necessitated online or phone access while in other cases in-person was necessary or preferable. Safety and privacy, in relation to COVID-19 were a major consideration for many women.

> There are benefits and drawbacks to both for trans people… online, the person may not be living in a safe environment, or they may be older and not tech literate. On the flipside there are higher vulnerabilities to COVID so people can attend online. **FG 1.**

The option of phone access was observed as particularly useful to those who had domestic environments which limited their privacy. Phone counselling meant they could engage in their car or when walking. For women with caring or childcare responsibilities that impacted their time and privacy, or who were not in supportive relationships, this option was particularly important. Without phone access options, as compared to computer-based options, a proportion of women would not be able to access talking services at all.

> The online thing has a role for young people but not in Direct Provision, there's no privacy. **FG 2.**

However, in the case of women caring for children or family members in the home, or who had transport or finance barriers, online support was often the only option as travel time and childcare presented barriers to attending in person. It was recommended that a full range of access options, many of which were provided routinely only as a result of COVID-19, are continued as this choice is important to engage the widest range of women possible.

4. A lack of housing and income have an outsize effect on women's access to mental health care

Stakeholder interviews

There was broad discussion by all contributors as to the very evident relationship between socio-economic status and access to mental health services. Specific factors were identified and form themes throughout this section of the report. For example, interviewees highlighted very different levels of access to mental health services between private clients, public clients and medical card holders. Getting a service is even more difficult for women with no-fixed address or who were transiently housed (in Direct Provision for example).

> Finance is a barrier, people's ability to pay and a lack of services in general, people must have a medical card, otherwise it's very limiting. There's some low-cost counselling but it's still beyond people's capacity. **Interviewee 1 (HSE)**

Contributors emphasised the necessity of meeting people's basic need for housing in conjunction with providing mental health services. The need to meet basic needs is a factor that should not be avoided, as interviewees highlighted, when basic survival needs are not met women will find it hard to focus on their mental health. Interviewees were of the strong opinion that a lack of housing and stability contributed to the mental health needs of women. For people presenting with homelessness and mental health issues, the immediate needs related to housing, safety and food, are therefore necessary to respond to in an interagency manner, while mental health supports are provided in a flexible manner.

Focus groups

Focus group contributors also highlighted economic barriers to access as a major cause for concern:

> Economic and resource issues that lead to ACEs (adverse childhood experiences). Like no access to a GP because of low socio-economic status. I experience people all the time who are told 'just ask your friends,' even getting a PPS number can take months. If you cannot access a GP, it's an economic issue. **FG 2.**

It was observed by practitioners that the necessary focus on 'Maslow's hierarchy of needs', means that other source issues, such as hormonal changes for instance, may be missed or deprioritised. The fact that homelessness could be used a barrier to prevent women from accessing mental health services was also noted. The focus group discussion on this area highlighted that the system and waiting period for exiting homelessness or Direct Provision and being granted HAP varies across the country, with some areas having expedited systems in place for vulnerable groups but in other areas of the country people could be waiting up to a year for payments to be approved. Interviewees called on a standard operating procedure for accessing housing allowance payments and expedited processes for more vulnerable groups of women particularly homeless women, women experiencing IPV and women in Direct Provision.

5. A two-tiered, overburdened health system results in marginalised groups not getting required services

Stakeholder interviews

A major concern for the majority of stakeholders was structural and systemic barriers for access to health care. The main issues raised included staff shortages, unacceptable length of being on waiting lists, inequity in the provision of services and lack of time to provide adequate supports due to time pressures:

> I think accessing GP services has become more difficult in general, so we need more staff and doctors. **Interviewee 6 (Professional advocacy group (GP))**

The overburdened health system had a direct impact on efficacy of provision of mental health services, with medical practitioners citing lack of time with patients as a barrier to providing an adequate service and time for referral. A critical factor was that consultation time did not allow for effective brief intervention regarding people presenting with mental health concerns and subsequent referral often involved long waiting times until people were actually seen.

> Time is a barrier. We do early medical abortions, that's funded but there's none for mental health and there should be but there's no funding for that. The typical 10-minute window is too brief. **Interviewee 6 (Professional advocacy group (GP))**

This resulted in a vacuum for vulnerable people. Stakeholders pointed to the inefficiency combined with the inequity of a two-tiered health system and called for one-tiered system providing universal healthcare.

Focus groups

A majority of focus group participants echoed the points raised by stakeholder interviewees.

> GPs seeking to understand and work through rather than just prescribing. But then GPs have no time for that, it's a challenge. **FG 3**

While others highlighted the pressing need to reduce waiting times for access to mental health services, for particular cohorts of women, for example women fleeing war:

> Every time they are thinking intrusive thoughts especially if their family are still there. They need a psych to talk to them. This is the main problem. They're waiting maybe a year, and this affects them, and they can't go to private because it's really expensive. **FG 4**

Women in addiction:

> A lot of these young people are not here now because they weren't supported …Then they can't get an appointment for 3 weeks which can be fatal. **FG 4**

Women who are trans:

> The waiting list is 7 years for adults and nothing is being done. **FG 1**

In rural areas waiting lists to access mental healthcare were also considered to be unacceptably long:

> The mental health of people who don't have a GP is an issue and this has a huge bearing on access to mental health and in (small town or county) it is an issue and people are waiting weeks even for priority access. **FG 4**

6. Domestic and intimate partner violence have a serious impact on women and girls' mental health

Stakeholder interviews

A minority of stakeholders mentioned intimate partner violence and the adverse effect it has on the mental health of women and girls. In particular they highlighted the inconsistency in applying thresholds for securing necessary supports for women. One stakeholder highlighted the added vulnerability of older women who may be isolated and caring for a partner who had been or still is a perpetrator of intimate partner violence:

> Older adults can be vulnerable, particularly if they don't have other relationships or family. They may be dependent on a husband where there is a history of intimate partner violence. **Interviewee 2 (HSE)**

Focus groups

A majority of focus group participants touched on intimate partner violence in some way. Many spoke about IPV as being a primary source of mental ill health among the women they serve. This HSE participant highlights the added mental health risks of women experiencing IPV.

> There's not a lot of research in the area but [a] recent UK study indicates that women are 3-4 times more likely to take their own life if they're a victim of domestic violence. Domestic violence went up during covid. We saw higher levels of mental health issues, but we didn't know how to deal with it. **FG 2**

Focus group contributors spoke about the structural and institutional frameworks the exacerbated the experiences of women experiencing IPV.

> The expectation that women (experiencing domestic violence) should leave their homes is outrageous. It [is] compounding the impact. The narrative is this is the way we should deal with domestic abuse. It's structural again and the right to property and his right to stay in the home property is more valuable than women's safety. **FG 3**

Other barriers to exiting IPV were highlighted such as difficulty of accessing refuges or waiting times for processing housing allowance payments.

> In this region a HAP application takes a year to process, the impact of not being able to get away from a partner is considerable. **FG 3**

Other providers of supports to women experiencing IPV highlighted the inequity of access for women who are trans such as being able to secure places in women's refuges.

> Regarding gender we assess and respect how someone (accessing DV services) identifies, but a block we have is providing accommodation and that adds trauma to their experience. On their birth cert they're assigned m/f their identity often isn't respected. It's changing though. **FG 4**

7. Addiction frequently deprioritises women's mental health

Stakeholder interviews

A third of interviewees and a minority of focus group participants highlighted the frequent inability of women to access mental health services when they are experiencing addiction issues (frequently called Dual Diagnosis)(Kelly & Holahan, 2022). This was due to a stated or practiced policy in a number of HSE mental health services that when co-morbidity exists, the onus for treatment lies with addiction services.

This practice can prevent women in significant need of assistance from attaining mental health supports from services. In particular, the additive effect of having a dual diagnosis and being homeless means those affected are excluded from accessing services:

> This practice affects people in addiction and homeless people which leads to trauma and marriage break-down because of economic issues. The inequality of distribution of resources is sending people over the edge in this country. **Interviewee 4 (Professional advocacy group)**

The fact that women's addiction issues can remain hidden, particularly in relation to alcohol and prescription medication, was also a cause for concern. The overuse of prescription medication was related to the stigma felt by women, as well as what one interviewee described as 'a lack of monitoring' by health practitioners. Interviewees viewed this as being a gendered issue disproportionately impacting women, which would benefit from further research. The nature of this dynamic is outlined below:

> Women can be more hidden, particularly older women over 50. It's hard to uncover because they are reluctant to seek help around alcohol and prescription drugs. Clients have been prescribed for years without review and it's then very hard to come off, it's definitely more common among women, they're given a repeat script for 10, 12 15 years. It's hard to know the impact of this. **Interviewee 1 (HSE)**

The majority of comments on this theme recognised the added complexity in providing mental health care for women experiencing addiction issues who were

also homeless. They drew connections between these challenges and the likelihood of present and past traumatic experiences, including trauma and abuse. The impact of high levels of past trauma was an underlying cause connecting multiple current day challenges, such as mental health, addiction, financial management, housing access and challenges in managing parenting roles.

Focus groups

Practitioners also highlighted the paradox that people with complex needs were being prevented from accessing mental health services.

> We can't take the young person if drugs are an issue, alcohol is ok! **FG 4**

When multiple challenges and parenting are interacting, interviewees commented that the focus of both mothers and service providers, can move away from the mother's needs and focus almost entirely on parenting. While the necessity of a focus on child safety was not disputed, it was noted that this scenario is a very gendered one, and one which also means that women's mental health can be deprioritised:

> Addiction often has that back story [abuse as children]. It impacts on how mothers can care for their children. Keeping themselves and their children safe becomes the focus. **FG 3**

The complex nature of being a primary caregiver; sometimes of fear of losing their children, compounded by trauma, (the source of which was often male), meant that women continued to feel unsafe when accessing services. Therefore, dedicated safe spaces should be provided for women seeking addiction or accommodation supports:

> Women have experienced much more trauma and men have often been involved in that and they don't want to access services where there are men, so a standalone service staffed and attended by women is essential. **FG 4**

8. The need for additional cultural diversity and cultural humility

Stakeholder interviews

Interviewees emphasised that service providers should view 'women' not as a homogeneous group but from an intersectional perspective. Lack of provision of culturally sensitive services to minoritised people, including trans people, gender variant people, women seeking international protection, ethnic and religious minority women, women who do not speak English and women with low levels of formal education was mentioned by the majority of contributors. Interviewees spoke about the specific needs of women and the often-additive effect of belonging to further minoritised groups, for example:

> Women have higher levels of self-harm and then also among the LGBTQI+ community generally. **HSE 4**

Some providers have considered how best to meet their clients' unique needs by providing a broad practitioner base from which clients can choose. They include gender, cultural and religious factors in the provision of services. However, these providers have also experienced the challenge of frontline practitioners who are not always culturally sensitive in their practice:

> When we recruit, we make sure there isn't a conflict that the therapist has, that they're neutral in general, some therapists may have limitations or preferences. For example, male, female, sexual orientation, religion. We've had for example, in the past, therapists focus on the particular Christian approaches attached to their own religious background. If we had a client who is Muslim, that could create a bad experience for that client. **Interviewee 7**

Contributors noted that cultural factors may impact engagement. Many reported becoming aware of the culturally specific needs of clients from diverse backgrounds and noted that the current services are not well designed to engage certain groups:

> In recent years we've had referrals from ethnic minorities where gender roles are very defined and that may be limiting in that they are then less likely to access services. **Interviewee 1 (HSE)**

Interviewees emphasised the need to examine culturally sensitive ways to engage with these communities.

Focus groups

When providers were committed to providing a service which supports diversity of client backgrounds, the availability of therapists who had the necessary language skills presented a barrier to the provision of services to some cohorts. For some services, the current solution to language barriers is to provide interpreters during sessions where possible. However, this presents other challenges e.g. privacy and being able to make choices in line with cultural or religious practices:

> Some cultures have very strong boundaries when speaking to a man or a woman which can make that relationship uncomfortable. Trust building is more challenging. **FG 4**

In small ethnic communities, having an interpreter from that same community can be problematic, as people may hold differing beliefs that constrain what the client feels can be discussed, and issues or fears of confidentiality can also arise. There were contributions from a number of services providing supports to, or with an interest in supporting, women from the Muslim community in particular.

> Muslim women are unseen and need more reaching out, sometimes for cultural reasons. Muslim women feeling they can't access domestic violence services. Their visibility wearing the hijab… they are more open to abuse and physical attack. **FG 4**

Interviewees highlighted that services were not culturally sensitive or particularly well informed in this regard. The unique visibility of women who wore the hijab compared to their male counterparts also acted as an added source of stress, as this culture identifier could be seen as symbol that incited more overt racism:

> It's our experiences that shape us, initially I had an extremely positive experience. But then I didn't wear the hijab... As soon as I wore the hijab that changed, I could see people seeing me negatively. **FG 4**

Contributors also highlighted the added vulnerability of young adult ethnic minority women living at home who were experiencing abuse, and the lack of systems and structures in place to provide services for this group.

> I can think of a Nigerian woman with sickle cell anaemia. She was living at home. Her mother had been abusive, but she found it very difficult to get support, it was very hard for her to access … She had to lose her family to gain support she needed. There are no protections in place for adult children living at home experiencing abuse. **FG 2**

A minority of contributors spoke about how services provided to Ukrainian women fleeing war did not meet the needs of those women and that uptake on services provided was low. Contributors recounted that initially service provision took the form of trauma-informed counselling and psychotherapy. High levels of social stigma regarding accessing mental health services within this community was not considered when designing supports. This was further compounded for women with children, who wished to remain strong for those children. This issue was also viewed as compounded by access issues caused by childcare commitments and lack of privacy where women were housed (women seeking international protection in temporary housing for example and women in Direct Provision). Where interpreters were provided, women were concerned that children who were present would understand what was being said and so often declined to engage in services.

> One woman said that the child is experiencing distress. I can't have this conversation because I have to be strong. **FG 3**

Interviewees spoke about seeking out information on how to be more culturally sensitive in the practice and the relative lack of resources available on the subject. They were aware of certain organisations who had carried out specific research on the needs of specific ethnic minority groups, or ethnic minority groups experiences in general but felt that more training opportunities were needed.

> In the counselling psych courses there's very little diversity training and trainees are mostly middle class and white. This presents problems for provision. **FG2**

A majority of contributors echoed the lack of diversity in the helping professions including counsellors, therapists and psychologists as a major issue.

> Money is a main barrier in a few different ways. Wouldn't it be fantastic if leaders in cultures could train as counsellors. So, if there was some kind of scholarships targeting community advocates. **FG 2**

Interviewees highlighted that cultural competence and humility was lacking across services which constituted very real barriers to social inclusion for minoritised women.

9. Women seeking international protection have a complexity of needs

Stakeholder interviews

The needs of women and girls seeking international protection was discussed by a minority of stakeholders. They discussed the further minoritised status of women and children from this cohort and the detrimental impact of living in Direct Provision on mental health. One interviewee emphasized the need for women in Direct Provision to have access to digital supports in particular phones to give autonomy.

Focus groups

A majority of focus group contributors discussed women seeking international protection. One contributor wished to highlight the different needs of ethnic minority women and newly arrived ethnic minority women seeking international protection. There were significant barriers to engagement for women seeking international protection compared to their male counterparts.

> The language is one of the key barriers, lack of understanding of how the system works, what institutions are in charge of what, not having informal knowledge that the 'host' culture would have. **FG 4**

For example, women seeking international protection tended to have lower levels of education compared to men in a comparable situation, and often did not have opportunities to learn English as they did not work outside the home. Some women may not be literate in their first language, and so written material may not be an effective way to communicate information to them. Women may not integrate with the community within which they reside or know how to access services.

> Women coming from particular developing countries have less education compared to men, for example Somali women tend to have high literacy difficulties. **FG 2**

Many focus group participants commented on living conditions in Direct Provision contributing to poor mental health. This was further exacerbated by the lack of privacy when trying to access services on the phone or online.

> A woman with two toddlers and infant twins sharing a room with four young children, any of us would go crazy in that situation. **FG 2**

Lack of privacy was also an issue particularly for women in Direct Provision.

> To what extent can I do a mental health assessment with children present? Or if they don't speak English then with an interpreter can children understand?

As was access to the necessary equipment and Wi-Fi, and the financial barriers paying for data in the absence of Wi-Fi. The location of Direct Provision centres and services (often remote or inaccessible to town), presented issues when trying accessing services.

> People are stuck in isolated places so beaming in via Webex is an option but invariably Direct Provision centres don't have good Wi-Fi and have to use their own data and choosing between that and communication, more barriers **FG 2**

10. Pathways to care for women who are trans need to be improved

Stakeholder interviews

Stakeholders emphasised the need for gender recognition, dignity and respect for trans people in the delivery of services. However, a minority of stakeholders discussed the need for further education and training for GPs and mental health providers on how best to support trans women. In particular practitioners who had completed training some time ago needed information and education in this regard.

Focus groups

Specialist services in the provision of supports to trans people including trans women highlighted the added barriers trans women face when wanting to access mental health services. The separation of pathways to accessing mental health supports for trans women was a particular concern.

> We need to stop looking at trans as some separate type of medicine, the needs are essentially the same our identity is not a mental health or physical condition… GPs need to be empowered and have proper training. GPs can refer cis people[3] to mental health supports.[4] **FG1**

A minority of contributors also talked about how access to gender affirmation service or the lack thereof compounded mental health issues, they cited the added stress of waiting lists and not-fit-for-service gender clinics, transphobia, and delayed intervention:

> The waiting list issue is definitely a barrier, I have personal experience of that and a lot can happen in that time. Appointments tended to take place during work hours which was difficult and sometimes the location was difficult. You could lose a day or half a day travelling. **FG 1**

One contributor reached out to expert services for advice on how best to support trans clients in therapy. They were unsure about how best to proceed with clients and highlighted the lack of robust information for practitioners providing supports to trans clients.

> Gender service advised me to not view providing therapy through a gender lens. But in the community, we're meeting people on that path, so there is unsureness among professionals about how well they're trained on gender… but there's not so much on gender and how to be able to deliver services equally to trans women **FG3**

For trans people the current model of care had implications for their mental health.

> In doing community work, it can't be stressed enough how the current model of care impacts my work. I've had people try to kill themselves

3 Cis or cisgender - Used to describe a person whose gender matches the body they were born with. Cambridge Dictionary.

4 A trans person who needs HRT or surgery publicly cannot access healthcare until they undergo an assessment by a psychiatric multidisciplinary team at the National Gender Service. Clarification provided by focus group member on review of their notes.

> after being in the gender clinic, people self-harming again, losing their jobs. **FG 1**

While many of the focus group contributors recognised a deficit in knowledge about how to support trans women, again, dedicated providers made suggestions for integration and inclusion of women in existing services serving women.

> Clinics for trans folk similar to the current menopause clinics might be a bridge but ultimately referral to general mental health services should come from GPs and if you have a psychiatric issue then you should be referred to a general psychiatrist. **FG 1**

11. Lack of childcare is a significant barrier to accessing services

Overall the ramifications of having childcare commitments and lack of childcare supports was one of the most common, tangible themes discussed across the interviews and focus groups.

Stakeholder interviews

Five stakeholders highlighted the need for childcare to be available to women accessing mental health supports, from student populations to women working in the home for whom privacy was an issue (women experiencing intimate partner violence or coercion for example). Some interviewees had experience of women wanting to access services, but being unable to, because they lacked supports of their own, and childcare was not available on an ad hoc basis to those seeking support, even if the mental health support itself was free (in higher education institutions for example).

> Childcare is one of the biggest barriers, for couples coming to therapy as well. I've seen cases where people have brought their children to therapy and the receptionist has minded the child. **Interviewee 11 (C&VS)**

Online supports were also unsuitable for women in Direct Provision or for older women who may not be tech savvy:

> Not everyone can access supports online, we would want a blended approach. We recognise childcare would make services more accessible. **Interviewee 5 (Professional advocacy group)**

Focus groups

The majority of focus group participants highlighted childcare as an issue that needed to be addressed. Not just childcare but caring for children presented challenges for some people wanting to access mental health services. The situation was perceived to be particularly tenuous for women with children from low socio-economic status areas and women with substance use problems for whom trust in services was low:

> But also fear of seeking help because fear that children will be taken away into care, particularly lone parents. **FG 3**

Women also 'stayed strong' for their children. This was noted for Ukrainian women fleeing war, where concealing mental health struggles was an attempt

to not worry their children. Women, particularly in their 30s – 50s, often delay accessing mental health services due to competing domestic and life responsibilities. This was considered a particular risk when women had multiple caring roles, included parents or other family members and/or children. It was noted that even when women were cohabiting with a male partner, these responsibilities were likely to fall much more to women than men in the family unit. One HSE contributor noted that childcare constituted a tangible block to many women trying to access mental health services, but noted that delivery on childcare for women trying to avail of services was unlikely.

> Mine is pie in the sky maybe, but a creche for the duration of women accessing primary care services. It's such a block- even in the larger services. **FG 4**

Another linked observation from three interviewees, was that women tend to have better natural or friend support networks than men. While these can support mental health, it was hypothesised that these support networks may also delay women accessing services when they need them, and so access services when they have reached crisis point as a result.

> I feel for women, there's just no time to be sick, the emotional labour. The mental load for women is high. The time it takes (to access support) means something else suffers. Prioritising their own health, women don't. **FG 4**

12. Menopause is not given sufficient consideration in policy or practice

Stakeholder interviews

A major theme was that menopause is not given sufficient attention, and that there is a lack of information and practitioner knowledge about how this affects mental health. This was seen as impacting women's ability to discuss this issue in the context of mental health. It was noted that the focus on menopause at the systems level focuses on treating the physical impacts of menopause at the exclusion of discussing mental health impacts:

> Regarding menopause, the health services response tends to be physical and not mental health focused... That worries me, that separation of physical and mental health, it should be more integrated. **Interviewee 3 (HSE)**

Other practitioners who raised this issue highlighted its potential relevance, but stated that they had very little information about how menopause impacts mental health, or how differences in endocrine function across lifespan impacts women in general. They suggested specific trainings on these areas for practitioners in particular. It was also noted that the issue has yet to be properly addressed in National Health Policy, which needs to be rectified:

> I think probably there isn't a lot of awareness of menopause and mental health... there might be individual awareness, but policies aren't stating this. **Interviewee 1 (HSE)**

However, some interviewees focused on the widespread lack of understanding of the interaction between reproductive and mental health, and added responsibilities at different life stages.

> There's a lack of understanding of reproductive and mental health and a life course perspective on that. Many women are caring for parents and going through menopause at the same time. That's so hard on mental health. **Interviewee 4 (Professional advocacy group)**

Interviewees also commented on the stigma associated with menopause, and how this presented a barrier to accessing services. There was an overlap between reluctance to attend, and expected bias from practitioners.

> Also, with regard to menopause there's that stigma. I've heard women who have said they've gone into their GP who have been dismissed because they're seen as hysterical women. **Interviewee 9 (HSE)**

Focus groups

A majority of focus group participants discussed menopause as a primary issue of concern. They highlighted the ignorance in the medical profession, and in mental health professions about accurately diagnosing for either physical, hormonal or mental health issues in such situations. Many gave concrete accounts of how this had a detrimental effect on women's mental and physical health which often had serious ramifications for their quality of life.

> The highest incidence of suicide among women is in that age bracket and we (HSE) don't ask about menopause. **FG 4**

And from another contributor:

> There are times, like menopause, when mental health can plummet. There needs to be HRT available. A lot of women are being given other meds. They're told they're depressed and are put on anti-depressants and it's hormonal. **FG 4**

Many commented on the lack of training in medicine on issues specifically impacting reproductive health for people who menstruate and menopause in particular.

> Why aren't the GPs educated in gender-sensitive issues? Why isn't there education? There's plenty about prostate cancer but not menopause? **FG 3**

Interviewees continued to highlight multiple examples where HSE and other services failed to take menopause into account for women or conducted inadequate testing for menopausal symptoms:

> It makes me realise that in AMHS, we don't think about the menopause. I spoke to a consultant, and they said they do yearly bloods and that was it. **FG 4**

Interviewees highlighted the invisibility of women who may have passed through menopause, were not in the 'typical 'age bracket, and may have had early-onset menopause or have undergone treatments resulting in menopause. Interviewees highlighted that it was not just menopause that was under considered (if it was considered as a source at all), but other reproductive or hormonal conditions that were under-diagnosed or were not understood.

> It's not just menopause also PMDD (Premenstrual dysphoric disorder) – and it's not understood and is often misdiagnosed as a mental health issue. **FG 2**

13. Stigma and shame present powerful internal barriers to accessing mental health care

Stakeholder interviews

A minor theme was that ingrained social stigma and personal shame related to mental health remains a significant issue for some women, and delays or prevents help seeking. Over half of interviewees noted that there are still societal groups where stigma and feelings of mental health shame remain intact and influential; and affect individual experience and access to services. Groups named as still experiencing resistance to asking for help, or talking openly about mental health included older people, people from the Traveller community, Ukrainian people, women seeking international protection from some African countries and those from a Muslim background. It should be noted that this list is not intended to be exhaustive, but reflects the stories or examples offered by interviewees, some of which are illustrated in the quotes below:

> I personally see access and readiness to accessing services as being much better than the past. Younger people are more open and engage with our social media; Insta and TikTok... Young people book thorough social media. They look for and access services: the older generations still have resistance. **Interviewee 7 (Private provider)**

One interviewee noted that there was still considerable stigma associated with seeking help for mental health issues in Eastern Europe while another noted that even the term 'mental health' carries stigma and shame for some women from African countries, they cited AkiDwA (AkiDwA, 2020) and their research with women seeking international protection on this issue.

Focus groups

Approximately half of focus group participants spoke about stigma and shame around accessing mental health supports for the people they serve. They highlighted particular minoritised groups, specifically the Traveller community, people from Muslim communities and women fleeing war in Ukraine, as groups who were resistant to seek help and supports for mental health struggles. In some cases, cultural values were contrary to seeking help outside the family or ethnic community, while other barriers included religious practices, which meant that women in particular could not engage with services provided by men, or in others unaccompanied by a chaperone. The lack of cultural sensitivity with regard to these practices meant that if women did seek help, they could not be sure their wishes would be respected or facilitated. However one contributor remarked that there was a will to understand, and that a raising of awareness, coupled with suitable provisions would likely be met by providers in a positive way.

14. Social prescribing and other proven early intervention and prevention strategies require more resourcing

This theme did not emerge from the interviews with stakeholders.

Focus groups

A majority of focus group participants spoke about specific community-based initiatives, with the objective to enhance participation and wellbeing, for people who were vulnerable, or at risk of reaching a threshold for crisis intervention services, or other mental health services. There were various functions for these initiatives: to provide women's spaces for women with high emotional labour commitments who had low levels of social supports, for women newly arrived in Ireland seeking international protection, for women who were resistant to seeking support from mental health services, and for women at certain stages in life (such as women experiencing menopause). One contributor spoke about a peer support group for women recently established in their locale:

> What struck me was the value of having a safe space, the most important piece. They were comfortable talking and being open there might be an assumption that women are great talkers, they were quite isolated. **FG 2**

Some organisations had re-evaluated the needs of some women; for example becoming more culturally aware of the needs of women fleeing war, and how to engage successfully with them:

> Yes, there was an expectation of trauma informed services for Ukrainian women fleeing war but there's a low uptake, it's better to have interventions at a community level with a consideration of language and culture. **FG**

However, some community supports were under pressure to 'hold' people who are waiting to access services:

> For trans folx, we have a lot of minority stress. Doctors ask 'Is it because you're trans (that you're not ok)?'. That can cause added barriers to accessing healthcare including mental healthcare. Peer support groups are having to hold too much, people are traumatised coming into those groups. **FG 1**

A majority of interviewees emphasised the need to expand community-based supports, facilities and opportunities for interaction, as a method of prevention and early intervention, that were not solely targeted at people who had reached a threshold for accessing mental health services. They advocated for the social prescribing model, with community supports and activities to back up these services, coupled with the expansion of this model beyond the current 30 locations where social prescribing supports are available.

15. Addressing gender bias and unconscious bias in the delivery of healthcare

Stakeholder interviews

The majority of stakeholders did not mention unconscious bias regarding gender, but one contributor spoke specifically about bias in research and drug trials. They highlighted the historical practice of having only male participants in drugs trails for new medicines, and although this practice changed in the 1990's, gender differences in results are often still not reported for clinical trials.

> A lot of research focuses on men as subjects not women in mind; there are so many gaps in knowledge which is all embedded in a patriarchal structure and services that are designed to suit men. **Interviewee 9 (HSE)**

Focus groups

Conversely over half of the focus group participants made some reference to experiences of bias for their own clients and service users when accessing medical and mental health services. They gave accounts of the dismissal of women's experience as being commonplace. For example, a disregard for listening to women's accounts of pain.

> We've seen both sides with GPs, physical interpreted as a mental health issue or vice versa. Pain management is not the default. The overall theme is a lack of collaboration between their HCP (health care professional) and them. Women are often not made aware of their choices and are often not involved in their own care plan. **FG 4**

Focus group interviewees recounted stories that had resulted in more complex and sometimes life-threatening health outcomes down the line, for example:

> A woman had a really sore ovary, she had a lovely GP, but he never followed up or referred her anywhere as a result she suffered two ectopic pregnancies. She didn't know where to go. **FG 4**

One contributor highlighted that many women were aware that they were less likely to be listened to than a man and that has an impact on the care they receive:

> The may bring their partner with them (to a GP) as they aren't taken as seriously. I'd agree with that (strong majority) the appointment goes differently. **FG 4**

These comments generated a number of comments from other participants in this group corroborating these accounts.

> I agree service providers need to be educated. There's so much implicit bias when it comes to women. Anyone in a position of power should have to look at their own biases. GPs don't know about a lot of things like menopause and periods. They need to educate themselves. **FG 4**

For newly arrived ethnic minority women, the issue was compounded by their lack of a support system, having little or no family support or a lack of advocacy supports:

> They have extended family at home but here they feel isolated and this causes mental health problems and then the system… GPs often dismisses the problem, so there's no solution and they can't get urgent service anyway. **FG 3**

16. People living in rural areas have disproportionate barriers to accessing services

Stakeholder interviews

A minority of stakeholders spoke about isolation of women in rural areas, women working in the home, women in Direct Provision Centres, and women experiencing intimate partner violence. Isolation could be psychological or physical. Some interviewees had been proactive in collaborating with other interested stakeholders, such as community centres and councils in tackling mental health. Particular initiatives such as the hub and spoke model of perinatal mental health were highlighted as being effective in service provision. Examples of collaboration and best practices in the support of women's mental health were recounted by some interviewees. One in particular spoke about a multi-stakeholder approach in their CHO:

> There's a lot of support for this in our CHO, we have an oversight group who get detailed feedback. There's definitely buy in. We communicate this in the Sharing for Life strategy - we have a learning community of practice which all regional officers would attend. **Interviewee 9 (HSE)**

Focus groups

Focus group participants also spoke about isolation. Direct Provision Centres are often innaccessible from the nearest towns and public transport. Also, the relocation of people when they exit Direct Provision presents challenges in accessing social supports as well as services. Likewise, trans people who lived in rural areas found the time and cost involved in accessing services prohibitive. Other focus group participants spoke about women in rural towns, who, despite the assumption that they had support systems, often felt isolated in a way that impacted their mental health. Women who had health issues during the perinatal period also found it difficult to access services, due to the prohibitive distance needed to travel to access specialist services.

> What's available in a women's local area so that's a barrier and then accessing services in their own community can be difficult, so there's a team in the Coombe (for perinatal mental health) but not everyone can travel to Dublin so there's very little for women in rural areas. **FG 4.**

This interviewee emphasised the value of providing those services and the considerable savings such services represented.

A minority of HSE and community and voluntary service focus group participants gave examples of initiatives that had been put in place to 'hold' people who were

potentially vulnerable. For example, initiatives targeted older adults, women working in the home, women seeking international protection and trans women. However, one commented on a lack of coherence, and sometimes overlapping services, while in other areas there were none. Examples of best practice were not readily identified, could be localised, and were not necessarily known to other services or areas. Some areas had supports, such as the social prescribing service.

> We now have a social prescriber - it's a new term for a very old concept to prevent social isolation, depression – to identify what matters for the person, not what's wrong with them. It takes the pressure off the medical professional. It's a really simple idea to battle the mental health crisis. It's a new HSE initiative that's not overly being promoted. When it works it works amazingly and people can self-refer. **FG 5**

Participants who worked in services in specific geographical regions highlighted vacuums in terms of service provision in certain areas and the lack of provision of certain gender specific services such as abortion services in some places.

> We'd have women with complicated pain and gynaecological issues too. There is a lack of access in the west of Ireland to abortion. This is a serious issue. Access to physical health services, things that bear down on mental health, that are linked.

17. Isolation and combined physical and mental health needs have a significant impact on older women's mental health

Stakeholder interviews

Two stakeholders discussed the mental health needs of women in later life. Considerations included isolation and the additive effect of physical and mental health needs. Experiences of quality of life in later life was compounded by socio-economic status. For example, older women living in rented accommodation or elder care residential centres often could not have pets. While a seemingly small issue, pet ownership could have a considerable impact on mental health. Contributors spoke about the impact of losing friend groups, and the death of loved ones or pets as contributing factors which compounded feelings of isolation.

Focus groups

A minority of focus group participants spoke about older adults and mental health. In particular they commented on reports of ageism from older women in the provision of services.

> There's something for me, the struggles are invisible a lot of the time e.g., older women, we're reaching out to older women and the issues, the bias and ageism was a serious issue. **FG 2**

It wasn't just loss of support systems, but living in conditions detrimental to older adults' mental health, such as living with an abusive partner, or having absent or abusive family members, which compounded mental health challenges for older adults.

> And the additional needed, physical, hearing, family push back or where the perpetrator of abuse is the carer. **FG 2.**

18. Social media can be a protective or risk factor

Stakeholder interviews

A minority of stakeholders spoke about the detrimental impact that social media can have on women and girls. In particular expectations of how to look and behave, and pressure to conform to unrealistic standards was something that impacted the mental health of women and girls. The effect of engagement with social media for women from all walks of life and the often negative and personalised experiences of women who engaged with social media platforms was a factor which exerted pressure on women.

Gendered online harassment and bullying were highlighted as factors impacting women's mental health by contributors. The disproportionate effect of pressures and expectations of families, and peers, and society in general, with regard to expectations of body image, lifestyle, and goals was highlighted by community and voluntary service in particular.

> Violence, sexualisation of women, cyber violence and bullying deeply affects women. More legislation is needed, and consequences, online especially, need to be looked at. **Interviewee 11 (C&VS)**

To counteract this pressure interviewees recommended legislation protecting women against online bullying and harassment and hate speech.

Focus groups

A minority of focus group participants also spoke about the negative impact that social media can have on their service users, not just in terms of engagement but also in terms of exposure to hate speech and disinformation.

> It just bleeds into everything so much, the rising negative narrative from the media compounds things and heightens stress of trans people to see these conversations. **FG 1**

However, some participants felt that there were positive and negative aspects to social media use depending on circumstances. While conceding that often the environment could be toxic and have harmful effects on women's mental health, there were aspects of social media which could support mental wellness.

> The online environment can provide a support structure. It can be a facilitator for different supports but can also be a means for harassment and cyberbullying. **FG 4.**

One group who represented ethnic minority women, spoke about how use of social media to provide a strengths-based 'space' for women was beneficial, and reduced feeling of isolation while also providing an opportunity to reduce the stigma around help-seeking for mental health issues. Another participant remarked on how social media platforms allowed newly arrived women to keep in touch with family which was particularly important during the initial period of coming to Ireland.

> Ethnic minority women use online to maintain links with their ethnic community at home and abroad. **FG 4.**

19. Perinatal mental health needs to be further understood and supports provided for specific groups of women

Stakeholder interviews

A small minority of stakeholders discussed perinatal mental health. They emphasised that approximately one quarter of people who have given birth had mental health issues ranging from mild to severe within the first year after having given birth. This also had implications for the additional need of infants and children of those primary caregivers, which resulted in a considerable cost to the government. There has been a recognition of this issue, and the specialist perinatal mental health service provides services to those women and their families. Interviewees recommended extending this service beyond the current hubs and spokes, to reach more women, particularly in isolated and rural areas.

Focus groups

A minority of focus group participants emphasised the needs of pregnant women and people. One focus group participant specialised in mental health supports for postnatal women.

> I see mental health as a spectrum, peri women need peer supports and for a lot of women there aren't spaces for that if you want baby massage you have to pay a load of money. The spaces for women to come together are few and far between. **FG 1**

Like the stakeholder interviewees, they emphasised the need for a whole-family approach to supports.

> If there are struggles, then both parties are struggling. During Covid partners were forgotten, they couldn't come in (to hospitals) why? What do they think that would do to men and couples and that can then impact the child. It has a knock-on effect. **FG 1**

What next?

Recommendations from stakeholders and frontline practitioners

This final section of all interviews and focus groups asked participants what practical, tangible, next steps could be taken to improve gender sensitivity in services in Ireland.

Stakeholder interviews

The majority of stakeholders highlighted the lack of provision of a gender-sensitive lens in current policy and government and HSE strategy. The first step to ensuring an integration of gender sensitivity lay with defining and then integrating gender sensitivity into all aspects of mental health provision.

They suggested ensuring that there was representation by women or people who acted as allies to women across all boards and agencies charged with the development of government strategy not just in terms of mental health but also physical health, housing, education in particular. Currently this was an issue not adequately addressed at higher management levels within the HSE or on strategy boards.

> It begins with things like ensuring gender balance on implementation panels, we have a really poor gender balance on *Sharing the Vision*, not by design but we did flag it. It's really important we do fix it. **Interviewee 2 (HSE)**

There should be an overarching, stated gender-sensitive policy and women should be considered a specific target group for access to funding both inside the HSE and for agencies working with or funded by the HSE.

Raising awareness of GSMH was an issue raised by a majority of interviewees. Education and training for all mental health practitioners was essential. Interviewees highlighted that the medical profession and nursing students and practitioners needed adequate training. This training should have an intersectional focus. Medical and nursing undergraduate courses should integrate gender sensitivity into all courses, including physical medicine and general, as well as mental health nursing. Given the move towards recovery models of care, consideration should be given to how to conceptualise and diagnose mental ill-health in this new paradigm of person-centered care.

For existing practitioners, courses and training should be rolled out and should take the form of online and in-person seminars. A minority of interviewees advocated strongly for the use of HSeLanD as a conduit for these courses. Materials such as flyers and virtual information materials should be provided to existing practitioners including GPs on GSMH literacy.

The majority of interviewees emphasised the need for an inclusive or intersectional approach to any steps taken. They highlighted the current barriers to accessing courses and training for minoritised groups, including people from the trans community, and ethnic and religious minority people. They emphasised

the lack of training places on courses, and financial and caring barriers, which existed for many people. They emphasised a need for a more diverse workforce across the board in the provision of mental health services. In order to achieve this, finances should be ringfenced for the provision of places on courses in mental health nursing, clinical psychology, counselling and psychotherapy courses for people coming from minoritised communities. Provision should be made for free or means tested childcare places for people wishing to undertake training. A clear framework outlining pathways to undertaking these courses should be developed and implemented.

Clear equality and diversity policies should be in place for all services. More importantly a clear strategy for the integration and implementation of that policy was key with clear evaluative frameworks for monitoring the efficacy of those strategies.

Following on from this recommendation, the need for well-informed policy was dependent on the provision of useful information to help identify need. Approximately half of interviewees discussed using data to inform decision making in the targeted provision of GSMH, and the need for a consistent and intelligent system for gathering information to inform policy and practice.

> Looking at demographics, who is and is not using the service and ask why. And measure outcomes for people, there is no consistent approach right now some are good, others not so much. **FG 2**

A minority of interviewees recommended a universal healthcare model and cited the barriers to accessing mental healthcare for public and medical card holders in particular. Access to GPs and other health services, including mental health services, should be uncoupled from a person's address or fixed abode. Interviewees recommended the provision of childcare places while people accessed one-to-one therapy on site. They also emphasised the need for choice between online and in-person in order to reach vulnerable women.

Focus group participants

Once again, focus group participants emphasised a requirement for the visibility of the specific needs of women and girls in policy, strategy and participation at government and HSE levels. A statement and recognition of gender sensitivity was a starting point. Gender-sensitive strategies should be built into any new strategy and integrated into existing ones. They also emphasised the need for the implementation of gender-sensitive polices in community and voluntary services, and for private providers of mental health services. The majority of participants emphasised the need for training and education for students and professionals.

Housing security was a cause for concern for participants and affected several groups of women including homeless women, women in Direct Provision and women seeking international protection, women experiencing domestic violence, and adult children at home experiencing violence from parents, women using illicit drugs, and women experiencing divorce. A coherent strategy to address the basic housing needs of vulnerable women while providing mental health supports were needed.

> Setting up basic conditions for someone to feel safe and secure if you

> think about it, that's often missing for women, finance, housing, unsafe relationships. There has to be a commitment to provide them from a societal perspective. **FG 3**

Those providing supports to specific groups of women gave examples of how this could be achieved. Women with children should have access to childcare during sessions. Flexibility of access to online vs in-person and out of hours services were needed. Women experiencing homelessness should have access to dedicated services including shelters staffed by women. Women who are trans need the removal of barriers to accessing mental health services, without recourse to gender clinicians. The education of GPs on the needs of trans people and the integration of mental health services access into mainstream services was paramount.

> There is a cohort of GPs that would love to be empowered to provide this. It would have a positive effect on the community and trans sense of self that cannot be underestimated. **FG 1**

Trans women should have access to IPV refuges serving women without fear of refusal. Women experiencing addiction should have access to mental health services in parallel or in conjunction with addiction supports. Women seeking international protection should have ways of accessing information that takes account of language barriers and possible literacy and educational disadvantage. Newly arrived migrants often do not have access to the tacit knowledge of the general population in terms of navigating 'the system'.

> Often information is text heavy and that is prohibitive. When it comes to reaching ethnic minority women information should be provided in simple language but in ways that also visually communicates i.e. uses images and icons. Ensure images are inclusive include images of women and ask how diverse those images are e.g. disability, hijab, ethnic minorities. **FG 4**

In conclusion, there is a strong appetite for the provision of gender-sensitive mental health from stakeholders, providers, advocates, and frontline workers in Ireland based on this research. Lack of visibility of GSMH in stated policy and strategy presents a considerable barrier to implementation. Contributors gave concrete suggestions for practical steps to beginning that path to a gender-sensitive mental health service at all levels. Recommendations drawn from the literature reviews and qualitative research conducted for this report are outlined below. To ensure that Recommendation 16 of *Sharing the Vision* is implemented in a gender-sensitive way, it is imperative that these recommendations are taken forward by the appropriate agencies as set out below.

6. Recommendations

These recommendations were co-developed with principal stakeholders, and are based on the findings from the literature reviews and the qualitative research conducted for this report. The literature reviews identified good practice guidelines namely:

- The need for gender-sensitive interventions
- Addressing the lack of gender sensitivity among professionals
- Gender-sensitivity is a core component of trauma-informed care
- Flexibility in approach , especially with those from marginalised backgrounds
- Accounting for gendered differences across the lifespan

Strengths and deficits in current practice in Ireland were identified in the thematic analysis of the conducted interviews and focus groups. The objective of the co-creation of these recommendations was to develop tangible and achievable actions based on the findings of this report. The summary of 31 recommendations is presented based on the CDC framework for effective implementation of policy and strategy grounded in the WHO social determinants of health model. The CDC is the national public health agency of the United States, however it is relevant in the Irish context as this model focuses on the non-medical factors that influence health outcomes and provides a useful framework for future action.

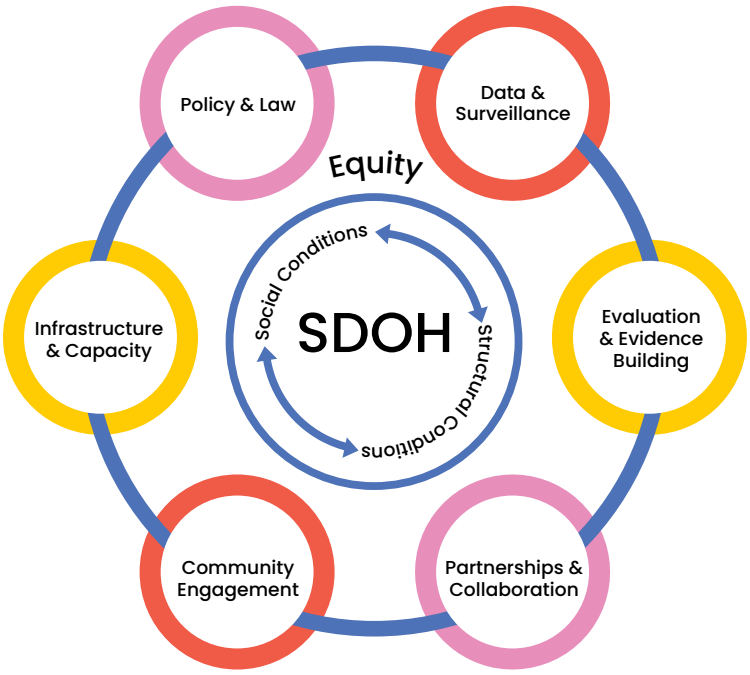

Figure 1. The Centers for Disease Control Social Determinants for Health Implementation Framework.

Policy and Law

1. Government to increase mental health funding as a portion of the health budget to deliver on the ambition of *Sharing the Vision*, particularly so services can reach most marginalised, and to allow for targeted services for women and girls.
2. The Department of Health to develop a clear strategy to increase the representation of marginalised groups from a range of backgrounds by developing a workforce plan to increase the number of mental health practitioners, therapists and counsellors available, through increased collaboration between the HSE and HEIs including sponsor programmes and bursaries, mentoring and social supports for people from diverse backgrounds.
3. The HSE to develop a counsellor grade which would remove barriers for qualified counsellors with accredited qualifications to deliver mental health supports within the HSE and help to increase capacity.
4. Government, Department of Housing, housing agencies and the HSE to adopt a 'mental health first model', so people with a dual diagnosis of addiction and mental health are not denied mental health supports.
5. Failing the abolition of Direct Provision, gender-specific accommodation should be provided by the Government as an option particularly for trafficked women, and gender-specific shelter accommodation provided by all agencies including hostels should be available to women, including women who are trans.
6. The Government and Department of Justice to examine current civil and criminal domestic violence legislation, with a view to putting mechanisms in place that do not unduly penalise the survivors of abuse in particular with regard to staying in the family home.
7. The Department of Justice to consider extending protections afforded partners of abusers which are already in place to children and adult children of parents and carers in the family home e.g., protection order mechanisms which can be triggered for children and adult children living at home who are the victims of domestic violence.
8. Given the move to community embedded mental health services for people with high needs and other presentations, the HSE to align mental health assessment for access to services in line with recovery-led, person-centred care as opposed to DSM/ICD criterion currently used.
9. Housing authorities to develop a common protocol to ensure the non-discriminatory provision of shelter and accommodation for trans people in a way that protects the dignity and rights of trans people.
10. The Government to expedite legislation on hate speech.

Data and Surveillance

11. Relevant agencies such as the HSE, CSO and ESRI to collect disaggregated data which includes demographic identifiers that will support an assessment of accessibility of mental health services to all marginalised groups and support a

gender analysis of access and efficacy of services. The Expert Advisory Group overseeing the development of the National Population Mental Health and Mental Health Research and Evaluation Strategy and Implementation Plan to include demographic identifiers that will support an assessment of accessibility of mental health services to all marginalised groups. Ensure that the HSE and community and voluntary services design their own demographic data collection systems to be compatible with these requirements.

12. The new integrated Case Management System (ICCMS), which will soon be in development as a national electronic health system for patients, clinicians, administrators to manage all aspects of planning in relation to healthcare across community services, should ensure data is captured by gender, provising interoperability with acute hospital systems.
13. The Government to make reporting of gender differences in all drug trials compulsory. Increase understanding of gender-specific health care e.g. endocrine system and drug interactions, the impact of physical and biological health on mental health from a gendered perspective.

Infrastructure and Capacity

14. All HEI's with medical, nursing, psychology, social work, counselling and psychotherapy and other relevant disciplines to integrate comprehensive GSMH training into third level training programmes in mental health.
15. Training should be developed with experts in medicine, nursing, psychology, social work and counselling and psychotherapy and experts by experience. Training should include:
    a. The interaction of gender-specific physiology, endocrinology and mental health
    b. The factors impacting women's mental health across lifespan including but not limited to adolescence, perinatal, menopause and later life
    c. How gender interacts with social determinants of health
    d. Conscious and unconscious bias and structural bias in medicine and psychology research and practice
    e. Societal inequality from a gendered perspective
    f. Cultural humility though a gendered perspective
    g. The experiences and specific needs of further minoritised groups regarding mental health including but not limited to:
        i. The Traveller Community
        ii. The Roma community
        iii. Asylum seekers and refugees
        iv. Women fleeing war and persecution
        v. Women living in Direct Provision
        vi. Women who are trans and people who are gender variant

7. The HSE to develop and deliver, or engage a partner to develop and deliver, intersectional GSMH CPD training to mental health and primary care health practitioners through online and in-person modules and seminars including but not limited to HSELanD; the HSE's online training and learning portal.
8. Health services to uncouple access to mental health services from home addresses for people without a permanent home, developing a protocol for women who experience domestic violence or are in Direct Provision, so they don't require a fixed address or a GP to access mental health help. For existing free counselling schemes, extend the range of referrers to include other agencies such as social workers and other community-based support services working with target groups.
9. The HSE to promote an understanding of GSMH as an approach through literacy campaigns targeting medical and mental health providers. The campaign should include clear actions or guidance as to how to enact GSMH in practice.
10. Adapt payment schemes so that services can provide hourly drop-in or booking based childcare options for parents and carers of children aligned with primary and community mental health settings. This would require changing the existing funding model (run through Pobal) to allow for sessional hourly provision in a way that is economically sustainable for creches that are connected to or contracted by health services. This change would be undertaken in consultation with community childcare providers.
11. Ensure that as many women as possible, and particularly marginalised women, women with disabilities and women experiencing domestic violence, have access to a choice of online and on-phone counselling, in addition to in-person mental health services. For services to be effective, this also requires that waiting lists are monitored and capacity is enhanced to a level which ensures that goal waiting times, at a point considered appropriate by mental health experts, can be attained.
12. Extend the free travel initiative to people who are homeless and people in Direct Provision.
13. Provide funding for extended mental health consultation time to GPs, similar to the current abortion services provision time, to deliver psychological first aid brief intervention to people experiencing mental health difficulties.

Community Engagement

14. Bolster social prescribing initiatives, community development and peer support programmes, supporting their role in early intervention for mild mental health issues.
15. All tate funded mental health services to provide a choice of therapist by gender to enhance choice and empowerment (following private practice models which outline the practitioners' availabilityalong with a brief biography). Where women require practitioners with specific languages or a translation service, issues such as cultural identity, confidentiality, and service

principles such as being non-judgemental should be discussed, and wherever possible practitioner choice that also considers these factors should be made available.

16. Develop a range of initiatives to reduce shame and stigma around mental health and support seeking, targeting marginalised communities and using community development approaches. This should be specific to particular at-risk cohorts of women most affected by cultural shame in relation to mental health, i.e. Eastern Europe communities, Muslim communities and people from the Traveller Community, perinatal women and women caring for young children and older adults. These initiatives to take an evidence-based community development approach and be led or codesigned and delivered by members of each community.
17. Consider culturally sensitive modes of delivery of mental health supports including group therapy models for specific cohorts (e.g., women from muslim communities, Traveller women.

Partnerships and Collaboration

18. Review and strengthen early engagement and onwards pathways to mental health supports for groups who face significant additional barriers to service access groups, particularly where there is stigma associated with mental health issues. For example identify specific engagement strategies for women and girls from Muslim communities, Ukraine, Roma and Traveller communities, parents of infants with limited social networks, and people seeking international protection. This action requires mental health services capacity to be increased to meet support needs, without lengthy waiting times, that are developed with participation of members of those communities.
19. Develop drop-in community-based mental health support services with outreach teams to support access to care for women in the commercial sex trade and those who have been trafficked.
20. Co-ordinated advocacy to focus on calling for a Housing First model, and adequate housing supply.
21. Develop interventions addressing the impact of social media, porn, online harassment, and the social pressures and expectations these fuel, on the mental health of women and girls. Integrate learning and effective recommendations into legislation, education and policy.
22. Develop systems within primary care for the early identification of mental health needs in early life, particularly school age years. This to be carried out in collaboration with schools and community mental health teams.

Evaluation and Evidence Building

23. HSE Mental Health Services to undertake an assessment of mental health services against the findings of this report and develop an action plan to implement key changes. Areas for improvement should be identified and may include:

a. Staff to have comprehensive cultural competence and humility training, which focuses on the particular needs of minoritised groups through an intersectional, gender-sensitive lens

b. Conduct a review of specialist counselling service availability to ensure services are accessible to specific minoritised groups that require unique expertise or language such as people seeking international protection from African countries, Ukraine, Poland and religious minority people including women from Muslim communities

c. Ensure efforts through partnerships or outreach, or other evidence programmes, to combat stigma and ensure pathways to services are more accessible for people from marginalised backgrounds

d. Offer online and in person options to ensure accessibility to women in a range of circumstances and locations.

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