CORA Cork Open Research Archive
Cartlann Taighde Oscailte Chorcaí

Title	An evaluation of homeless women's experiences of mental health services in Cork - a feminist perspective
Authors	Connolly, Trish
Publication date	2013-10-04
Original Citation	Connolly, T. (2013) An evaluation of homeless women's experiences of mental health services in Cork - a feminist perspective. Cork: Community-Academic Research Links, University College Cork.
Type of publication	Report
Link to publisher's version	https://www.ucc.ie/en/scishop/rr/
Rights	©2013, Trish Connolly.
Download date	2026-10-30 02:55:56
Item downloaded from	https://hdl.handle.net/10468/8506



UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

An Evaluation of Homeless Women's Experiences of Mental Health Services in Cork - A Feminist Perspective

Trish Connolly

CARL Research Project

Name of student(s):	Trish Connolly
Name of civil society organization/community group:	Good Shepherd Aftercare Services
Supervisor(s):	Lydia Sapouna
Name and year of course:	MA Women's Studies
Date completed:	04th October 2013

What is Community-Academic Research Links?

Community Academic Research Links (CARL) is a service provided by research institutes for the Civil Society Organisations (CSOs) in their region which can be grass roots groups, single issue temporary groups, but also well structured organisations. Research for the CSOs is carried out free of financial cost as much as possible.

CARL seek to:

- provide civil society with knowledge and skills through research and education;
- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

What is a CSO?

We define CSOs as groups who are non-governmental, non-profit, not representing commercial interests, and/or pursuing a common purpose in the public interest. These groups include: trade unions, NGOs, professional associations, charities, grass-roots organisations, organisations that involve citizens in local and municipal life, churches and religious committees, and so on.

Why is this report on the web?

The research agreement between the CSO, student and CARL/University states that the results of the study must be made public. We are committed to the public and free dissemination of research results.

How do I reference this report?

Author (year) Project Title, [online], School of Applied Social Studies, Community- Academic Research Links/University College Cork, Available from: www.ucc.ie/en/scishop/completed/ [Accessed on: date].

How can I find out more about the Community-Academic Research Links and the Living Knowledge Network?

The UCC CARL website has further information on the background and operation of the Community-Academic Research Links at University College Cork, Ireland. http://carl.ucc.ie

CARL is part of an international network of Science Shops. You can read more about this vibrant community and its activities on this website: www.scienceshops.org

Disclaimer

Notwithstanding the contributions by the University and its staff, the University gives no warranty as to the accuracy of the project report or the suitability of any material contained in it for either general or specific purposes. It will be for the Client Group, or users, to ensure that any outcome from the project meets safety and other requirements. The Client Group agrees not to hold the University responsible in respect of any use of the project results. Notwithstanding this disclaimer, it is a matter of record that many student projects have been completed to a very high standard and to the satisfaction of the Client Group.

Executive Summary

Background to the study:

Women's experiences of mental health and homelessness are multi-faceted and undeniably intertwined. Yet both are social problems hidden from the political and social agenda despite calls from women's groups and lobbyists (NWCI & Women's Health Council) to change this. The 'revolving door' between mental health services and homelessness is a clear indication that services do not adequately respond to these women's needs. The Good Shepherd Aftercare services (hereafter referred to as GSS) have taken the initiative to research this area due to an increasing number of their clients presenting with mental health difficulties. The GSS anticipates the findings will enable them to tailor services that would meet the client's specific needs.

Objectives:

The overall objectives of this study are to firstly: review the literature relating to women's mental health and homelessness from a feminist perspective. Secondly: to compile a list of mental health support services in the Cork area. Thirdly: to gain the perspectives of the women who access the GSS on what their experiences of mental health services were, to use this information to address 'gaps' in current service and identify areas where innovative change can be applied.

Methodology:

The methodology used was feminist research methodologies. The theoretical perspectives applied were that of gender, feminism as it applies to patriarchal power relations in psychiatry and androcentrism in researching mental health. The literature was analyzed from a feminist perspective. The literature used in the review was that of mental health service users' narratives, and other feminist researchers. Knowledge of the women's experiences was gathered through a qualitative approach using reflective interviewing methods. The Findings were evaluated using the Mental Health Reform (2013) Framework – The Five Core Components of Recovery Orientated Mental Health Service.

Results:

Women's experiences of mental distress were integrated with that of homelessness and the

impact this has on their lives. The findings correlated with that of other research in Ireland (Doyle, 2011., Mayock & Sheridan, 2011, NWCI, 2005). Women's experiences of mental distress and homelessness are not being responded to as an interconnected or gendered issue in health strategy or social policy (AVFC, 2006., The Way Home 2008-2013).

Evaluating the Recovery Orientated nature of psychiatric services:

The women interviewed expressed that did not feel listened to by psychiatric professionals. They experienced little hope within psychiatric services, finding them to exacerbate already existing stigma, labeling isolation. An apparent lack of choice and participation by service users was noticeable throughout the study

The findings showed only modest progress in implementing the ethics of a recovery based mental health service. However, the women gained valuable support from community services that helped them with other aspects of recovery such as personal development, self -esteem, social inclusion and counseling. Many of these supports were accessed via the GSS.

Recommendations and Implications of the Research Findings:

The literature review, findings from other research in Ireland and this study all echo the same message: women's homelessness and mental health need to be addressed in a way that responds to their specific (gendered) needs on both a personal and social level. Women are not being *listened to* in terms of what they see as empowering them towards recovery. This has a direct implication for other areas identified by mental health strategies as being integral to mental health recovery – areas such as hope, choice, participation and inclusion.

The women interviewed and narratives observed during the literature review both called for a mental health service that saw women listened to, respected and valued as active participants in their own recovery and not as passive recipients of psychiatric care. The recommendation is for further research in this area using feminist research methods as they identify with the gendered experience of mental health, homelessness and recovery. It is also recommended that service – users have the opportunity to participate in researching mental health (in the context of homelessness) as part of a growing trend in participatory mental health services (Ramon, S., 2006 & Chamberlain, 2005).

DECLARATION

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledgeable in the text. Also all names have been changed of the individuals who took part in the research to protect their identity.

Signed: Trish Connolly

Date: 04/10/2013

Acknowledgments

Thank-you to the women who participated in the interviews for this research, it is not easy to share personal stories to this depth but your honesty is invaluable. I hope this research will be a part of the change we so deserve and as so well put by yourselves – *the stronger must lead the way*-. Thank you for your strength.

To Sandra McAvoy and Lydia Sapouna for your never-ending patience and faith, I cannot thank you enough.

For A True Survivor:

Mary (spuddy) Murphy

"In the arms of the Angels…may you find some comfort here."

Prologue

Nobody close to me died, a natural disaster didn't wipe out all I had, yet in what seemed to be just as short a space of time these things happen and with little or no warning I still thought I had lost everything – most of all myself.

I had supposedly gone mad - what authors' Corry and Tubridy aptly describe as what we consider 'a fate worse than death' (2001, Prologue). I found myself quickly stripped of any role other than that of a sick person and isolated due to the distrustful nature of my *condition*. What is noteworthy is that the reason for my distress (others call it madness) was a traumatic event (and its consequences) that would and certainly has brought even the strongest to their knees: I was well and truly flat on my face, never mind my knees and I thought it was *me,* my inherent weakness, fault and genetic disposition (as my parents never tire of proclaiming). It was only in trying to peel myself up from the mandatory rough, grey industrial carpet in the psychiatric unit and swearing I would never see it from that angle again, that I discovered I was neither alone in this numb, despairing world nor were my parents (or society) entirely correct in their supposition.

During the treks in and out of the doctor's surgeries, hospitals and therapy centres I asked myself over and over again: 'Where did she go?' where did that adept and frivolous person go (I was doing a degree, had a job, a life) and who in the hell is the skinny, rocking and scowling medicated mess that she left in her place? Why is everyone suddenly telling me that I can't make my own decisions or look after myself '*because of the way I am'*, what way am I? It was never pointed out to me that I was simply afraid. Alas no, because within the hierarchies that exist in healthcare being terrified is substituted for the more technical term anxiety thus justifying the prescription of the anti-anxiety drug and there you have it: simple problem, simple solution. Except that for those of us in the guinea-pig category of pharmaceutical capitalism it is never that straightforward: Especially so if you are a woman and a double jeopardy for a homeless woman. Women experiencing mental distress become marginalised and even more so without a safe place called home, yet services still do not recognise the role this has in distress or recovery. My experience of distress and subsequent discovery of the risk this poses to having a (safe) place called home became the catalyst for feminist inquiry into homeless women's experience of mental health. Being a scowling, medicated mess is harder still with no safe place and nowhere to call home. I was humbled to discover the enormous strength that exists in those who make it home in their hearts.

Terminological Note

Mental health, disorder or 'illness' are widely accepted terms used to describe the impact of stress or trauma and health services related to emotional distress. Interestingly, a special issue of Feminist Review 'Women and Mental Health' (Alldred *et al* 2001) draws attention to the problematic nature of referring to emotional distress as a 'health' issue. The discourse of *health* serves to draw stressful emotional experiences into the realm of medical discourse hence the disease or 'illness' psychiatric care model.

To medicalise women's distress produces an "*individualising, apolitical, biologistic understanding…as in other areas then, feminists would question the necessary benefits for women arising from medical understandings of their experience*" (*ibid:1*). The findings from the literature substantiate the view that these benefits are few other than to translate the human experience into medical language for the benefit of the professional: To make 'ill' the normal responses to abnormal situations (Corry & Tubridy, 2001 & 2005).

Feminists argue that it serves to provide an avenue through which patriarchal power justifies itself (Busfield, 1996., Ussher, 1991 & 2011 *et al).*

However, our socio-cultural trend still favours the 'illness' or 'disease' model (seemingly reluctant to dislodge itself from a comfort zone). This is despite on-going efforts of advocates of mental health reform which proves that labelling people as mentally ill is stigmatising and oppressive. It does nothing to address the problems of human, distressing experiences or the potential for recovery.

Having survived this 'illness' and transcended the oppressive 'disease' imposed upon my unsuspecting self the researcher, along with the voices of other survivors that emerge from personal survival and recovery narratives prefer the term 'human distress'. Most of the health strategy, health and social policy documents and other types of literature still refer to human distress as mental illness or mental health - hence the interchangeable references throughout the following chapters.

Abbreviations

GSS Good Shepherd Services

CARL Community Academic Research Links

WHC Women's Health Council

MHR Mental Health Reform

MHC Mental Health Commission

DoHC Department of Health & Children

NWCI National Women's Council of Ireland

AVFC A Vision for Change

AA Alcoholics Anonymous

NA Narcotics Anonymous

WHO World Health Organization

Table of Contents

Chapter 1: Introduction ……12

Introduction to the CSO: The Good Shepherd Aftercare Service

Research Rationale

Why Research Mental Health?

Homelessness and Women's mental health

Researching Women's Homelessness & Mental Health: A Feminist issue

The Research Question

The Research Aims

Chapter 2: Methodology……..…….21

The Researcher's Position

Introduction

Feminist Research Methodology & it's relation to the research questions

Theoretical Perspectives

Feminism:

Feminist Epistemology and the data collection

Exploring Homeless Women's mental Health through A Feminist Lens

Feminism & Positivism

Androcentrism

Power

Gender

Method

The Literature review

Compiling the List of services

Reflective Interviewing

Chapter 3: The Literature Review ……36

What do we mean by Mental Health?

Bio-Medical Perspectives on Mental Health

Changing Paradigms in Mental Health: An Integrative Framework

Mapping Madness - The History of Mental Illness, Feminist Perspectives

Medicalising Women's Experiences of Distress

Recovery

Women, Homelessness and Mental Health

Homeless Women's Mental Health: Social policy & Health Strategy in Ireland

Mental Health Strategy & Policy: The Case for Gender Sensitivity

Chapter 4: The Research Findings & Data Analysis …….54

Selecting the Data: The five 'core components' of Recovery

The Recovery Model as a Relevant Data Selection criteria for Homeless Women

The five 'core components'

Conclusion

Chapter 5: Recommendations & Conclusions ……69

Evaluating the Women's Experiences using the MHR Recovery Ethos: The five key building blocks of a recovery approach

Exploring Homeless Women's Mental Health from A Feminist Perspective – Did it satisfy the research aims?

Recommendations

Reflective Piece ……..75

Researching From the inside out

Bibliography

Appendix 1: The List of Support Services

Appendix 2: The Interview Guidelines

Appendix 3: The Interview Transcripts.

Chapter 1: Introduction

Introduction

This chapter introduces the research topic: feminist perspectives on homeless women's experience of mental distress. Women's homelessness is an under-researched area on both a national and international level (Baptista, 1990., Norris & Keane, 2000.,Bowpit *et al,* 2011.,Mayock & Sheridan, 2012). A familiarity of the subject of women's mental health in the context of homelessness is offered through an introduction to the work of the organisation on behalf of whom the research is being carried out – The Good Shepherd Aftercare Services (GSS).

The chapter will also provide the rationale for undertaking this piece of work as part of the CARL initiative. It includes an outline of the research questions identified by the GSS, the research aims and what the anticipated outcomes may be.

Introduction to the CSO: The Good Shepherd Aftercare Service

The Good Shepherd Service is a voluntary organisation that has been providing accommodation and support to vulnerable women and children for over 40 years. It supports women, young girls and children who have experienced homelessness through a combination of residential, educational and support services. The mission of the organisation is:

"Through trusting relationships, we help women who are vulnerable to homelessness to live more fulfilled and self-sufficient lives"

The GSS Cork fulfil this mission through incorporating crisis support service *Edel House*, *Riverview* accommodation services for homeless teenage girls, *Aftercare services* which supports women vulnerable to homelessness out in the community and *Bruac Eile* educational support services for girls.

The GSS have sought assistance with research into the support services for women with mental health issues in the Cork area, to be carried out through a qualitative interview process with the women who access the Good Shepherd *Aftercare Service* for support.

Aftercare: The Aftercare Team assists people who are homeless to move out of homelessness into sustainable housing and achieve independent living. It is a client led service working on a one to one basis. The team works as an integral part of the overall Good Shepherd Service in partnership with other agencies both statutory and voluntary. A free and confidential service is offered to girls, women and families.

Objectives of the aftercare service

- To support residents of Good Shepherd Services who have been out of home in their transition to independent living
- To actively involve each person in decision making and planning

While housing is important, the service also provides information and advice on a wide variety of topics:

- Practical & emotional support
- Links to community services
- Parenting support
- Personal development opportunities
- Links to therapy services
- Rights & entitlements
- Accompaniment to meetings with other agencies / professionals
- Social activities
- Training courses

(Information provided by latest updated website: http://www.goodshepherdservices.ie/what-we-do/aftercare/).

Research Rationale

The research explores homeless women's experiences of mental health from a feminist perspective. The following paragraphs outline the motivations for this exploration.
The fact that such a large number of people struggle with maintaining positive mental health justifies any research. In addition to this the over-representation of women in medical diagnostic categories of mental illness (Breggin, 1991., WHC, 2005.,Ussher, 2011) and their under-representation in research (specifically homeless women) gives reason to dedicate an inquiry into women's experiences.

Why Research Mental Health?

Challenges to our mental health are an ever-present facet of the existences of women, men and children living in Ireland. Mental health is recognised by the World Health Organisation (WHO) as being:

> "*A pervasive feature of society… found in people of all regions, all countries and all societies…present in men and women at all stages of the life course…"*

The Irish Mental Health Reform's (MHR) analysis of mental health in Ireland in 2012[1] outlines national and international studies that suggest 25% of the population will experience a mental health difficulty at some point in their lives. It also states that 44% of people in Ireland have had a direct experience of mental health problems - either their own or within family/friends. The same analysis imparts that mental health support services have not been prioritised by the government and indicates that the quality of services 'lags behind' international best practice with an over-reliance on the medical model and in-patient treatment.

[1] Mental Health Reform (2012). Mental Health in Ireland.

Homelessness and Women's mental health:

"It's a well understood and documented fact that poverty and social exclusion lie at the root of homelessness. Housing is an important part of the solution, but homelessness is about much more than having a house. It is also about physical and mental health, it is about drug and alcohol use and misuse and it is often about the complex needs of individuals who find themselves on the margins of society"

(GSS Annual Report 2011:6).

73% of a sample population of homeless women who participated in an Irish study [2] were found to have experienced some form of mental health problem - the most common found to be depression (70%).[3] In a study of the health needs of women who are homeless in Cork 52% of those who participated had a 'diagnosed' mental health condition (GSS & Cork Simon Community, 2011:8). The Women's Health Council (2005:68) in a study of vulnerable groups of women - observes that homelessness can function to:

"Exacerbate every stress and adverse psychological outcome that has been documented for women in general".

The same study highlights the reality that homeless women face increased risks to their health and points out that mental 'illness' can be a cause as much as a consequence of homelessness in Ireland. Patients leaving mental health institutions in Ireland have been found to be at a higher risk of homelessness[4]. From a review of current research (Women's Health Council 2005, Mental Health Reform, Mayock & Sheridan 2012, Doyle, 2011) evidence suggests that there is a need for a greater investment in the provision of appropriate mental healthcare and rehabilitation schemes that will address these problems thus preventing the 'vicious cycle' (Keane, 2012) of homelessness and mental health.

[2] Mayock, P. & Sheridan, S. (2012) *Women's 'Journeys' to Homelessness: Key Findings from a Biographical Study of Homeless Women in Ireland* Dublin: School of Social Work and Social Policy and Children's Research Centre, Trinity College Dublin.
[3] Smith, McGee & Shannon, 2001 *in* WHC: 2005:69.
[4] Keane, M. (2012) Findings form a study of homeless women in Ireland.

Researching Women's Homelessness & Mental Health: A Feminist issue.

The National Women's Council of Ireland (NWCI) in its' consideration of the health of Irish women from a feminist perspective produced a paper on women's health:

"*In order to influence policy and offer ways forward in developing a health service that meets the interests and needs of women in Ireland"*

(NWCI, 2006:3).

The rationale of this publication states that the NWCI:

"*Considers it both timely and opportune to address the issue of the health of women…from a feminist perspective*"

(2006:4).

Feminist research takes the gendered experience of social issues such as homelessness and mental health into account. It considers men and women to hold differing views on social reality and everyday life due to their ascribed social roles and status. The implications of not considering gender in research mean skewed findings in relation to need - health services are 'planned and provided' based on a population approach. This approach does not take gender into consideration, despite knowledge that women may experience disease and require treatment different to men (WHO, 2001, *In: Barry, 2008:57).* The result of this is policy and service provision that does not meet the needs of its' gendered recipients and does not reflect the social reality in which their experiences of distress occur.

Concepts of mental health include: subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realise one's intellectual and emotional potential (*WHC: 2005).* The needs classified in a focus-group researched by Scheyett (2006) reflect these definitions of mental health yet it notes (*ibid*: 408) that there are difficulties exploring the issues that arise because:

*"The actual voices of women have emerged in only a limited number of studies… (*there exists*) the paucity of research that has been grounded in the voices of women with mental illnesses…"*

The recommendation of the NWCI 2006 publication '*Women's health in Ireland'* highlights a need for an '*investment in research to bridge the knowledge gaps and inform policy*'.

Findings from the most recent key study of homeless women in Ireland (Mayock & Sheridan, 2012) conclude that women's mental health and homelessness has often been overlooked in the past. It is hoped that a gendered perspective (such as feminist research) can "*critically inform and influence policy and help to ensure that services work appropriately and effectively to meet the needs of homeless women"*[5] . It is anticipated that this research will be a step forward towards achieving the hopes the research of the Women's Health Council and The Mayock and Sheridan study has expressed.

[5] Mayock, P and Sheridan, S (2012) Women's 'journey's' to homelessness: key findings from a biographical study of homeless women in Ireland.

The Research Question

The research proposed by the GSS seeks to evaluate women's experiences of mental health services in Cork from a feminist perspective; this is to include a feminist analysis on existing literature and policy, and fieldwork which seeks to:

1. Identify the groups and agencies that offer support to women with mental health problems in the Cork area, and to compile a database of these services including a brief description of the agency/service and the referral criteria that would benefit the clients of the aftercare service.
2. The second part of the research proposes to qualitatively interview the women who access the GSS aftercare services with the aim of finding out how many, if any, of the identified agencies and services had been used, what they felt was good about these services and what areas were lacking and what barriers were preventing the women from availing of these supports (Proposed 6 interviews).
3. The final phase of the research is to collate all of the information gathered with a view to posing questions to identify what the women believed were the 'ideal models of service' that would meet their needs and also to 'highlight any gaps' in the current services. This final phase seeks to assist the Good Shepherd services in evaluating where innovation in services is necessary in order to develop 'tailored supports to meet our client's specific needs'.

The questions outlined by the GSS reflect the research rationale in that they call for an approach which explores the gendered nature of the experiences of homeless women and mental health.

Undertaking this research as part of the CARL initiative presents the opportunity to fulfil the needs of the GSS and that of CARL services through alerting community support services to the importance of gendered health service. It also contributes to enhancing the understanding of stakeholders to the needs of homeless women in relation to adequate services through the use of feminist research methods.

The Research Aims

Using the questions outlined by the GSS as a guide and working according to objectives of CARL, the research seeks to bring together an in-depth evaluation of homeless women's experiences of mental health services through a feminist review of literature, mental health strategy and policy.

It aims to:

- Explore homeless women's needs in relation to mental health services in order to fill 'knowledge gaps' identified by previous women's health researchers.
- A fundamental aim of the researcher to demonstrate the capacity that feminist research from a service-users' perspective has on meeting the needs of specific groups.
- Build supportive and trusting relationships with the participants of the GSS in keeping with their own service ethos, with the view to providing the opportunity for respectful and active service-user participation in research, practice and service provision.

Chapter 2 Methodology

The Researcher's Position

Before describing the methodology used it is imperative to note the knowledge and value position the researcher has come from as it constitutes a significant part of the feminist stance underlying the study.

"To capture the current state of knowledge…and speculation…the author has interviewed dozens of experts – psychiatrists, psychologists…"

(Strong, M. 1998: xvi).

The above quote is taken from the introductory paragraphs of the book '*A Bright Red Scream*' in which author Marilee Strong researches the meanings behind self- mutilating and 'the language of pain'. Experiences of self-mutilation as an expression or symptoms of mental health and distress made this title worth investigating. In reading the first pages it could not be overlooked that the *experts* listed as interviewees did not include us – the people who had lived and spoken this or other languages of pain. Strong's work mirrors that of predominant approaches to researching in mental healthcare. Professional opinions are prioritised as being 'expert' with a complimentary paraphrase to prove the point gleaned from a stack of questionnaires that have been dutifully scattered about waiting rooms.

In contrast to the traditional approach, this research, as with other feminist methods of knowledge gathering uses the service user experience as both the researcher position and as expert knowledge. There are, according to the director of education and training, National Empowerment Centre (Judi Chamberlain):

"A growing number of academically qualified researchers who are also users/survivors, and they bring great value to their work by nature of this dual role"

(Chamberlain, J, 2005:13).

Though traditionally outside of research practice, the researcher is undertaking this study from the multiple perspectives of service user, researched and researcher. The researcher deviates from scholastic tradition by the use of a somewhat emic approach. This approach is research from what Kane and Brun (2001) describe not only as research from 'the inside out', but an approach that is active as a technique used to support feminist methodology.

Introduction

This chapter provides a description of the methodological approach used to carry out the research. It gives an account of the way in which the information was collected and analysed and offers a justification for this approach. The chapter aims to provide an exploration of the beneficial links between feminist research and homeless women's mental health. Theoretically, this chapter posits that it is the *way* in which knowledge of this subject area has been 'captured' (androcentric research) that is one of the barriers to effective mental health care for women. It argues that homeless women occupy a subordinated position within a psychiatric, male- dominated space that has served to further alienate them from society and acts as a barrier to recovery, participation, choice and inclusion.

Feminist Research Methodology & it's relation to the research questions

The research proposed by the GSS seeks to evaluate women's experiences of mental health services from a feminist perspective, including a feminist analysis on existing literature and policy. This section indicates how feminist research methods meet this requirement, with a particular emphasis on challenging power imbalances in psychiatry and shifting the focus on participation and empowerment.

> *'Feminist interventions, particularly around counselling and therapy services have…delivered a fertile ground of conceptual tensions and contestations on power and empowerment within mental health services'*
>
> (Alldred *et al,* 2001:3).

Having the opportunity to narrate one's experiences, especially traumatic or distressing events have proven to be empowering in nature (Gray, 2006). The methodology (reflective interviewing) used to gather together the knowledge of the participants reflects this empowerment in that it allows the women involved to speak of their own survival and recovery in a more natural manner. This in turn enhances the women's opportunity to change the way support services are rendered, echoing the intended direction of feminist research practice:

> *"Feminist research goals foster empowerment and emancipation for women…researchers often apply their findings in the service of promoting social change and justice for women"*
>
> (Brooks & Hesse-Biber, 2007:5).

The second and third phases of the research evaluate women's experiences in order to highlight any gaps in services and to use the knowledge gathered to identify innovative ways in which services can be tailored to meet women's needs. The process and findings of this research seek to evidence the potential to promote social change in that they can address the needs of a marginalised group who have not – as unearthed by the literature review – had the opportunity to voice their needs in terms of mental health services.

Theoretical Perspectives

A theory can be broadly explained as a term that places a context on why something exists or to explain the meaning of it and expose the underlying processes. The theoretical framework engages with feminist epistemology, gender and power as underlying factors in understanding women's mental health and the way society responds to it. This is done in an effort to reflect the need for more than one theoretical stance to understand the diversity of experiences of women who are homeless and the paths that lead them there. The epistemological stance that the research rests upon is that of feminist epistemology that involves an 'appreciation' of the gendered nature of knowledge of the research topic.

Pathways to homelessness are a diversified phenomenon and added to this are the multifaceted factors contributing to mental health. This is why there are several theories explored in this thesis. Including multiple theories is a practice that supports the feminist ethos. It provides a framework within which to explore a diverse topic with the expectation of effecting change. To limit the study to one theory would do no justice to the varied experiences of the participants as individuals contributing valuable insight to the subject area.

Feminism

What is feminism?

"Generally seen as one of the most influential social movements that has brought about the 'most enduring and progressive transformation of human society"

(Buchanan, 2010: 166).

In her introduction to *The Essential Feminist Reader* (2007) Estelle Freedman effectively summarises feminism as: 'the belief that women have the same human capacities as men'(2007: xi). A capacity that far outweighs the historically 'deeply held beliefs' about female physical, moral and intellectual inferiority that justified patriarchal laws requiring them to be submissive to male governance (In the case of this study to the patriarchal nature

of psychiatric care). Freedman documents that critics began to argue that 'common humanity far overshadows the biological distinctions of sex' (*ibid: xii)*, hence the evolution of the feminist thought that began to inspire political movement on a global scale. Freedman presents feminism in the context of a former timescale when 'men held formal power…women across cultures found myriad ways to transcend or resist patriarchal rule' (*ibid: xi)*. While women *are* finding ways to transcend patriarchal rule (or in the case of this thesis patriarchal structure). It could be wishful thinking on the part of the author to assume formal power (especially in psychiatry) is not still currently held in the majority by men.

Feminist Epistemology and the data collection:

'Feminism is a window onto the social reality…'

(Hesse-Biber & Leavy. 2007: Preface).

Feminist epistemology (in this study) is used to explore homeless women's experiences as understood in the terms of a male-dominated (androcentric) and traditional (positivist) psychiatric approach to mental health. This involves the value position that gender and power are key factors in understanding homeless women's experiences of mental health and are necessary for the emancipation from male preconceptions and vital to recovery.

Epistemological Assumptions Essential to This Thesis: So as to justify the rationale for the application of feminist research methodologies, the following paragraphs compare it to conventional research methods with the aim of highlighting both its distinctive features and usefulness as a method of inquiry into the experiences of homeless women who have used mental health services in Cork.

Exploring Homeless Women's mental Health through A Feminist Lens

Relating to the position of women within the structures that are in place to respond to what the biomedical psychiatric model have coined 'illness', it is evident by the over-representation of women in psychiatric diagnoses (Breggin, 1991, Ussher, 2011 *et al)* that as women we have yet to 'transcend' this social structure.

The chapter illustrates the potential use of feminist research practice as a renewed method of exploring the needs of homeless women experiencing mental illness in Ireland. This is specifically so as a vehicle through which 'illness' is *re*-presented as human distress thus more accurately reflecting the issue in the light of the social reality in which it occurs. Viewing women's distress through the lens of feminism allows one to see their individual and personal experiences viewed as strengths and as having validity in the recovery process, a perspective authors Stoppard and McMullen (2000) document as not traditionally adopted by psychiatric intervention:

"*Most critically from feminist and social constructionist perspectives women's accounts of their subjective experiences are not treated as having validity in their own right*".

It is argued that it is insight gained from these subjective experiences that lend more value to the recovery process than that of the biomedical interventions. This is on the basis that they take into account a more holistic sense and are both therapeutic to those they seek to serve and empowering as a recovery and research tool.

Set against the backdrop of a patriarchal and male dominated model of 'care' that is permeated by issues of gender, power and oppression, feminist research practice – mainly that of the narrative accounts of women's experiences- seeks to illuminate the both the restrictions current psychiatric models of care has on recovery and inclusion for homeless women and to substantiate the empowering role feminist research has as a knowledge base.

Feminism & Positivism

Conventional social research is primarily carried out using positivism as its underlying epistemological assumption. Positivism can be explained as "the way in which humans use science to ask how things work, rather than why they are there" (Buchanan, 2010:371). Positivism "holds that in any occurrence there is one true set of events – 'the facts' (Byrne & Lentin, 2000:63). Feminism disagrees with this assumption, seeing the truth as being "meaning which is established or constructed through the research process in consultation with all the participants" (*ibid: 63*). The search for a 'grand theory' rejected, the goal for feminism is not to produce one theory to explain the position of all women, but to provide a framework which is "capable of accommodating the diversity of women's lives" (Byrne & Lentin, 2000:63).

Androcentrism

Androcentrism can be described as what 19th century feminist Charlotte P. Gilman characterises as:

> *"Western thought's orientation around a male point of view, with the result that what was treated as common sense or universal was in fact a reflection of male identity and values"* (Buchanan, 2010:20).

An examination of Anderson's (1995) theory of Androcentrism in the context of science (psychiatry) and bias leads to the central theme expressed by the methodological approach in this thesis. It posits that it is the *means* by which knowledge of homeless women's mental health that acts a barrier to recovery orientated services for women. This leads to gaps in knowledge and understanding in mental health service response. Homelessness and mental health are a gendered experience with social meanings: This renders traditional, positivist in research and knowledge inept as they are based on androcentric research findings.

Power

> *"Women are abused in psychiatry as they are in any other power structure…That psychiatric abuses of women exceed the norm in society derives from that fact that its legal authority is excessive and its orientation is power and control"*
>
> (Breggin, 1991:324).

A functionalist perspective delineates the purposes of psychiatry as it is applied to homeless women's mental health as a traditional method through which patriarchy justifies itself. Supposedly for their own good women are segregated not only from their identity, social roles, minds and bodies but also from general society: from life. Those of us who have gotten out of hand, who refuse to succumb to the limited gender role woman is allowed to have are tamed in a more tacit manner often of which we are unaware.

The transfer of this ownership of body and mind from person to profession was uncovered during the literature review. It is included here with the intention of raising the awareness of the link between psychiatric practice and the disempowerment of women. Feminist perspectives on trauma and abuse draw interesting parallels between the effects of professional psychiatric interventions and traumatic experiences; both violate the body, mind and spirit of women and forcibly remove the woman from herself into a space where she becomes an object upon which to project the fantasy of power.

Gender

For the purposes of this chapter gender is broadly defined using pilgrim's (2005) description of the "role division of men and women in society. Sex refers to descriptions of a division based on biological features…gender is a social description and sex is a biological one" (Pilgrim, 2005:188). Pilgrim, amongst others studying the relationship between gender and mental health (Busfield, Ussher, Showalter) highlights the complex relationship between gender and the field of mental health particularly when it comes to social roles, over representation of women in specific diagnostic categories and contradictions in psychiatric responses to human distress. Psychiatry as a branch of medicine has its focus on the sex distinctions or biology and not on the social or gendered features of the human experience. Its interventions do not take into consideration the social or gendered nature of the lived experiences. It is argued then, that psychiatry is not a valid response to the lived and highly gendered experience of emotional distress, yet it remains the predominant response to mental health care in Ireland.

In feminist theory and methodology gender is considered as one of the 'fundamental categories' (Bloom, 1998:137) used for the analysis and critique of social and political systems such as mental healthcare. According to Bloom (1998:138) the purpose of using gender as an analytical category is to account for and overturn patriarchal domination in order to create social change. Bloom illustrates exactly the rationale for using gender analysis in this research. The researcher argues that mental health is a gendered experience but that women's voices are submerged in a system that gives precedence to maleness. In order to become emancipated from powerful male dominated responses to human distress that subordinate the female experience we need renewed ways of researching mental health – gendered responses to gendered experiences.

Method

1.The Literature review

The literature review (pp 36-54) is the process through which a progressive narrowing of the dual topic of women's homelessness and mental health experience is achieved. Since the area is quite a substantial one and spans more than a single discipline (i.e. medical, sociological, historical) it is the objective of the review to provide an analysis of some of the central themes, and indicate links with other studies within the field of homelessness, women and mental health.

A review of the literature provides a justification for the exploration of the topic of feminist, gendered approaches to homeless women's experiences of mental health. It demonstrates the way in which women's mental health has its roots in history yet develops within contemporary research. It also emphasises some of the fundamental principles and thinking within the research area identified. Major issues and debates, political standpoints and main questions and problems that have been addressed are explored within the review.

A review of literature on homeless women, gender and mental health from feminist perspectives gave way to some interesting studies carried out by other students in the area of mental health. An exploration of the history of mental health services such as institutionalisation and the development of psychiatry was carried out via some seminal works documenting the subordination and gross mal-treatment of women. In order to contextualise the subject, and for up-to-date statistics and findings, some of the supporting evidence is taken from Irish newspaper/media sources that feature mental health.
A review of the work of others identifies methodological assumptions and research strategies previously employed, and highlights the consequences of an absence of certain types of research methodology (i.e. ethnographical and participatory/action research) in homelessness and mental health services that the literature review seeks to represent. Through the process of reviewing some of these methodologies -and their positive outcomes in other areas- the evaluation of current literature will provide grounds for an argument towards reconsideration in the methodology applied in researching mental health services for homeless women.

2. Compiling the List of services

See Appendix 1 For Booklet of Support Service in Cork.

As set out by the GSS:

Identify the groups and agencies that offer support to women with mental health issues in the Cork area, and compile a database of these services including a brief description of the agency/service and referral criteria that would benefit the clients of the aftercare service.

Why Identify these Particular Services?

Themes that emerged during previous research in which a group of women accessing the GSS crisis service participated[6] highlighted that in relation to pathways into homelessness, all of the women interviewed mentioned the experience of "*traumatic and difficult childhoods and other sufferings and distresses in their lives*" (2011:44). It is important to note that not all of the women accessing the GSS present with mental health problems or have suffered traumatic abuses. However, findings from the literature review indicate a strong link between childhood difficulty and adult trauma with poor mental health[7]. This can have an adverse effect on coping with stress and social skills such as personal development and self-esteem (particularly with survivors of domestic and sexual violence- (SAVI, 2002: CH:5). Compiling a list of services providing support and training in these areas can assist women in learning about what is available to them. This could benefit them as an aid to learn skills, helping them to sustain their recovery.

Using primary research methods the first stage began by reviewing print versions of Local Directories of Services –voluntary & statutory-and internet searches of national/local support services. Selection Criteria for services is based upon the client group identified in the Research Proposal – Women over the age of 18 who have experienced homelessness and Mental Health Issues. The emerging themes and findings of the 2011 study mentioned above were also taken into consideration in selecting and sourcing support services addressing personal development and self-esteem.

[6] Doyle, E (2011) Is A House Enough? Service Users' Perspectives On the Reason for Repeat Admissions to A Female Homeless Service (Edel House). School of Applied Social Studies/University College Cork. Available Online

[7] UN Commission on the status of women, fifty-seventh session: 4th -15th March 2013, P14., The SAVI Report., Letters: 'Cut Price Therapy and the trauma underlying mental ill health', the guardian, 7th November 2012., Hegadoren, K.M. et al, (2006) Posttraumatic stress disorder part III.

Compiling the list of services and its' presentation was influenced by several other initiatives following the same objective of the GSS (with different target groups). The researcher collected other lists, booklets and directories from community services in an effort to ascertain the format that would be most accessible and user-friendly. Feedback from other services as well as consultation with a graphic designer indicated that concise, well directed information presented in booklet format was the most likely to be effective.

Participatory Action Research: Working in partnership with the good shepherd aftercare services

The researcher met with the aftercare services manager to take preparatory measures for the research study.

Conducting Relevant Background research – the literature review and policy analysis carried out prior to collaboration with the aftercare services afforded a wealth of information relating to homelessness and women's mental health. It gave an understanding of the variables associated with researching the topic, theoretical approaches and key findings of other studies. It was agreed that there was a gap current knowledge specifically relative to women's homelessness and mental health. Further literary analysis was undertaken by the researcher as part of the interview preparation following the theme of service users' as research participants. This resulted in a more informed position –especially in the context of Irish research.

Recruitment of participants – the aftercare services manager agreed to undertake the process of recruiting participants based on a familiarity with the women using the services. The women interviewed represented the diversity in the GSS Client profile and individual experiences. This allowed for greater scope in exploring the experiences women had and the needs identified by them.

Gaining Consent for the study – access to aftercare services as a location for interviews was discussed. The interview guidelines were forwarded to the service manager prior to scheduling the interviews to allow for feedback regarding their content.

Scheduling Interviews – For ethical reasons a particular emphasis given on the location of the interviews. It was decided early on in the research design that the aftercare services premises would be used to conduct the interviews as the women would already be familiar with the location. It would be the easiest place for participants in terms of transport, allowed for privacy and, if necessary, support from the manager following the interview itself. Given

that the nature of the issues being discussed are of a sensitive and personal nature this was considered as a protective and supportive measure. It was considered- through a discussion with the aftercare services manager- that interviewing those under the age of 18 may pose some ethical questions. The decision was taken to interview only those over the age of 18 so as to avoid unnecessary or potentially distressing situations.

3.Reflective Interviewing

The second part of the research proposes to qualitatively interview the women who access the GSS aftercare services with the aim of finding out how many, if any, of the identified agencies and services had been used, what they felt was good about these services and what areas were lacking and what barriers were preventing the women from availing of these supports (Proposed 6 interviews).

Qualitative interviews are those in which an interviewer 'generates talk' with an individual or group 'for the purposes of eliciting spoken, rather than written data to examine research problems' (Roulston: 2010:10). In keeping with the ethics of feminist research, the interviews were semi-structured and designed to explore the research topic through the use of open questions. The reason for this is that the questions could 'provide broad parameters within which the interviewees can formulate answers in their own words concerning topics specified by the interviewer' (Roulston:2010:12). Preparation for the interviews included:

- A familiarity on behalf of the researcher in the area of women's mental health and homelessness, in particular social and personal issues lead to distress and homelessness. There has been research studies carried out in larger Irish city areas (Cork & Dublin, see literature review) though there did not appear to be any focusing exclusively on mental health needs – these were taken into consideration but as part of a broader set of social factors.
- Considering the ethics of researching marginalised and/or vulnerable women: taking into account their position, respecting individual experiences and the knowledge they may or may not feel comfortable with sharing.
- Being sensitive to their needs before, during and after the interview process.
- Structuring the interview questions in a manner which would ensure that the research objectives were met and were sensitive to the needs of the women.

The questions needed to be formatted to ensure that there was a certain amount of information gathered (to address the research questions identified by the good shepherd services). At the same time these questions would need some structure to the order in which they were posed so as to act as:
(a) An introduction to the topic (that specified by the interviewer),
(b) A guide to the interview, and
(c) A method through which the participants could voice their needs, in their own words.

- Planning the interview using open questions and 'probes': Inviting the interviewees to tell their story generates conversation about the topic/begins the flow, while probes can be used to further explore certain questions. Using probes reflects feminist research values in that they 'use the participant's own words to generate question that elicit further description' (Roulston: 2010:13).

Using reflective interviewing and open questioning is a less formal approach than traditional methods and is also less intimidating for the participants as they have more scope for involvement. Power imbalances often play a substantial role in the research process which acts as a barrier in communication between the researcher and participants. Using reflective interviewing as a means through which knowledge is acquired intends to decrease if not, ideally to eliminate any power imbalances that may be experienced. The consequences of using this style of interview aspire to being the production of knowledge that more accurately reflects the experiences of the women involved, what their needs are, how they can be met. It also aims to ensure that the interview has been an empowering experience for them.

Qualitative Interviews can generate large amounts of data all of which would be beyond the scope of the thesis to include. The methodological criteria in selecting material that will be included is to enter verbatim extracts from the interviews. During the interviews the women were informed of the intention of the researcher to use these direct quotes in the thesis itself. This was done as part of the consent process and to make the women aware that the written piece would be forwarded to the centre-manager and would be available for feedback. Making the use of the interview transcripts clear, and providing the opportunity for feedback addresses the ethics of feminist research.

Putting it all together

The final phase of the research is to collate all of the information gathered with a view to posing questions to identify what the women believed were the 'ideal models of service' that would meet their needs and also to 'highlight any gaps' in the current services. This final phase seeks to assist the Good Shepherd services in evaluating where innovation in services is necessary in order to develop 'tailored supports to meet our client's specific needs'.

Highlighting the gaps – Evaluating the findings through the MHR Recovery Approach.

During the research process there was a significant development relating to mental health services in the area of practice guidelines. This was a publication by the Mental Health Reform (McDaid, April 2013) Entitled *Recovery…what you should expect from a good quality mental health service.* The publication outlines the "five key building blocks of a recovery-orientated approach", it identifies five "core components" of a recovery-orientated service as being part of a recovery ethos:

Hope: Professionals must convey an expectation of recovery.

Listening: Professionals must listen to service users with attentiveness.

Partnership: Working with service-users as equal partners in their own care is essential to redressing the traditional power imbalances between service-users and professionals.

Choice: Service-users must be offered choices – of treatments and therapies…in the absence of choices…people are essentially denied their right to make their own decisions over their own mental health care.

Social Inclusion: services have an important role to play in supporting people to participate in their local community, have social relationships and engage in meaningful activities including education and employment. These include helping those at risk of homelessness to secure housing.

The decision was taken to sort the information according to this ethos. The reasons twofold: Firstly, the five themes reflect many of the core values of feminist research and its aims, particularly the emphasis on listening to people's voices, so that they can "name their own world" (Byrne & Lentin, 2000:105) .

For the theorists cited above, feminist research is seen as a collaborative approach working in partnership with women in order to achieve social change. The partnership approach taken in the interview process reflects this and the potential for social inclusion that the research provides. Secondly; using the five core components runs parallel with the subject nature of the questions explored in the interviewing process: exploring choice, service-user involvement, being listened to and having a voice. Implementing these five components also serves as a way in which the women's experiences of support services can be evaluated, thus providing the opportunity to identify which specific areas need further improvement and which areas are most well developed. Considering that the publication was developed in collaboration with current service-users in Ireland it seemed appropriate to implement it in this study.

Conclusion:

From its infancy the research unearthed an awareness of the need to re-present women's mental health as human distress rather than as an illness *and* to make women visible within health and homelessness policy framework. A review of current Irish health strategies and the responses to them (A Vision for change, Mental Health Reform Commission and the National Women's Council of Ireland, The Way Home 2008-2013) see homeless women over-represented within psychiatric services and under-represented on the political agenda. It witnesses their lived experiences of distress lost in the translation of normal reactions (such as sadness, fear) to abnormal situations (homelessness, violence) into psychiatric illness.

Traditional research methods in mental health originate from biomedical discourse and are scientific in nature. Evident by a review of social policy failings to adequately (if at all) address the *gender* differentiation required to respond to the needs of women *or* to facilitate visibility of homeless women in mental health care are obvious. Traditional methods are ineffective in addressing the psychosocial aspects imperative to recovery. The predominant medical model informing current policy does little to alleviate the distressing symptoms it supposedly addresses. Research by Crowe & Taylor (*In:* Sapouna & Herrmann, 2006:57-67) state that:

"…most professionals believe that mental illness is a permanent condition. As long as the general framework for mental health is located within a disease based framework, mental health services and professionals will continue to provide services based on what they believe is best for the person. Social policy and care practice will continue to be misinformed, in that the needs will be of those of the service system and not the person".

It can be concluded that it is the traditional methods through which the information directing services is collected that is partly responsible for the gulf that exists between homeless women and the facilities they access when the symptoms of their distress become overwhelming.

Chapter 3 The Literature Review

Introduction

The final phase of the research proposed by the Good Shepherd Aftercare Service seeks to 'highlight any gaps' in current mental health support services and assist them in '*evaluating where innovation in services is necessary'*.
A feminist analysis of the literature pertaining to mental health services considers women at the intersection between homelessness, mental health and the gendered experience of emotional distress. The process of the review anticipates that by drawing on existing feminist research relating to these three aspects, the findings will support the interview finding in identifying where any gaps exist and what innovative measures can be used to address these.

The literature review is written from a feminist standpoint. The topic being researched incorporates three variables: gender, experiences of homelessness and experiences of mental health support services. The review considers the experiences of the women who participated in the interviews at the *intersection* of gender, homelessness and mental health and progressively narrows a large body of work to that which was deemed relevant to make the study practical.

The Aims & Objectives of the Review:

- To provide a general summary of previous feminist research in a national and European context regarding women's homelessness and mental health services. It will draw conclusions that support the rationale for carrying out research from a feminist perspective. '*General population studies often exclude marginalised groups*' (SAVI, 2002:54). There is a '*dearth*' of research in relation to women's homelessness in Ireland and even less examining their specific mental health service needs. The literature review covers the main findings in an Irish context in what has been recently researched in relation to homeless women's experiences of services. It also draws attention to some of the gaps in current studies emphasising the lack of research in specialised services for homeless women.
- To provide an overview of key terms & definitions of mental health & recovery as uncovered by the literature review. Recovery orientated services have been campaigned for by service user groups. A recovery orientated concept empowers people and comes from a place of understanding, reciprocation and hope. It runs

contrary to traditional models of psychiatric care and it a vital part of innovative service provision that supports women who experience distress.

- To present a general account of the history of social and institutional responses to women's mental health. This serves as a background against which current developments are located and highlights that we have not simply transcended the '*barbaric practices of psychiatry in modern practice*' (Rapley, 2011:vii) – but that the historical is inextricably linked to the contemporary.
- The literature review critiques traditional and biomedical mental health paradigms. This brings to light the problem of an over-reliance on medical responses to human distress and on women's subordinated position within health services.

What do we mean by Mental Health?

The difficulty with defining mental health is that it is not easy to 'draw a firm line' between healthy/unhealthy mental states as what is normal and what is not varies thus undermining attempts at a specific definition.
Pilgrim (2009:4) notes that the term mental health services has- since the second world war- replaced the term psychiatric services. The definition given to psychiatric diagnosis is also subject to variability; Pilgrim defines it as 'the application of a medical label to a psychological abnormality' (2009:6).

In the foreword to the 2005 (P.5) publication on Women's Mental Health in Ireland the WHC summarises the development of how we have come to characterize mental health. It states that what has been perceived to *constitute* mental health has changed over the centuries for various reasons – such as cultural dynamics and political and social change. The Council also (disappointingly) outline that despite these changes the presence of mental distress has been taken by both professional and non-professional as:

"Evidence of social as well as biological deviance… people who experience mental health problems have been deemed unfit to participate in social life".

This is a rather stigmatising view that current service-user groups challenge. Health correspondent for the Irish Times newspaper Paul Cullen reported that mental health stigma was 'fuelled by a lack of understanding…and prevents people from accessing support…62% of people said they would discriminate against hiring someone with a history of mental illness on the grounds that they may be unreliable' (Cullen, P, 2012). During the interviews

for this study several women spoke of how a clear lack of understanding by family left them feeling hopeless and isolated. The concept of recovery, though in existence for quite some time has been slow to make its' impact on the general and professional public.

Clearly, there are misconceptions regarding mental distress and the 'paradigm shift' called for by Advocates of Mental Health Reform and women's groups (such as the National Women's council and the women's health council) is vital to better understanding of this issue.

However, more favourable towards the recovery paradigm and progressive definitions include:

"*Concepts of Mental Health include subjective well -being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realise one's intellectual and emotional potential*"

(WHO, 2003: *Investing In Mental health, in* WHC, 2005:6).

In an Irish context mental health has come to be defined as:

"*The experience of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired, and some form of help is usually needed for recovery*".

(Mental Health Ireland, 2004)

"Mental health is used positively to indicate a state of psychological well-being, negatively to indicate its opposite or euphemistically to indicate facilities used by, or imposed upon, people with mental health problems (as in 'mental health services')"

(Pilgrim, 2009:3).

Bio-Medical Perspectives On Mental Health

Biological theories adopted by psychiatry focus on the presence/absence of physical symptoms and behaviours (considered deviant rather than responses to emotional distress) as indicators of mental ill-health. Psychiatric approaches aims to restore – via chemical intervention- the physical self to a baseline where normal functioning or at least maintenance is achieved. Though the absence or suppression of discomforting symptoms may provide temporary relief, there are many problems with dominant biomedical definitions of mental distress. In addition to hazardous side-effects from medication, it virtually denies context. To

medicalise symptoms of emotional distress '*deemphasises to the point of denial*' (Breggin, 1991:327) the psychological, social or spiritual self. One of the women interviewed for this study emphasised the spiritual aspect of her recovery as being 'life-saving', something she did not find within psychiatric care.

Feminist critiques of the biomedical model are the fact that biological factors play a significant role in diagnoses. Women are more vulnerable to gender-bias in the diagnostic process based on the traditional obsession medicine has with the female body as 'deviant'. Examples of this are evident by the 'hormone theory' in which female sex hormones have been viewed as being responsible for deviance of body and mind was widely used in psychiatry. In a publication dedicated to the study of women's 'madness', Ussher (2011) describes the attitudes of psychiatric practice and women's 'greater propensity to madness … attributed to the reproductive body', genetics or chemically produced (2011:18). The same publication outlines how substantial research across both genders has rendered traditional medical views linking women's physiology and mental illness to be inaccurate. In the context of depression and the subject of higher rates of diagnoses in women " a meta-analysis of four community and two twin studies, containing 20,000 participants, did not find any gender difference in hereditability" (2011:21).

A feminist analysis of mental health care strategies in Ireland (Quality and Fairness – A Health System for you, 2001, Vision for Change 2006 and MHR Ireland's guiding documents and manifesto, 2008) are still predominantly medical in their approach.

Changing Paradigms in Mental Health: An Integrative Framework

An integrative framework considers psychological and social factors as influencing the manifestations of mental distress in both women and men and does not focus primarily the biological factors. This is more likely to incorporate the gendered experiences of distress (not to mention the gendered experience of homelessness) and lessen the chance of gender bias in diagnosis. Authors Morrow and Chappell (1998) state that the social factors involved in mental well-being cannot be overlooked "women's mental health cannot be understood in isolation from the social conditions of their lives" (1998:3 *in* WHC, 2005:13). The same can be said of psychological factors and the gender-specific nature of emotional development, the social values attached to gender roles and the expression of emotion – what is acceptable as feminine or masculine – and stereotyped gender roles in western cultures.

Mental health and emotional distress is subject to scrutiny from a variety of angles. This results in a subject area seemingly so broad that it would appear to filter through all boundaries of the human expereince. While reviewing the classifications, explanations, symptoms and meanings - in an effort to find a suitable definition to use as a point of reference for this research - created a web of 'psy' jargon that bore questionable resemblance to descriptions of human experience documented in the narratives of research participants. It is also interesting to note again that the 'experts' consulted by various organisations or bodies - in their efforts to define mental health/distress – were primarily from a variety of professions such as psychiatry, psychology and social workers. It was not apparent throughout the review of key documents in homelessness or mental healthcare that the voices of those whose well-being was being directed were taken to be expert.

Mapping Madness - The History of Mental Illness, Feminist Perspectives

It is the intention of the researcher not to dwell on the historical practices within medical and social spheres as this has already been well documented in other studies (Foucault, 1971., Schowalter, 1987., Shorter, 1997., Pilgrim & Rodgers, 1999). The purpose of this section is to present a brief historical summary to be used as evidence for the need for overdue change in mental health care practice and policy.

Williams (2012) *Rethinking Madness'* opening chapter on terminology used in the exploration of psychosis and recovery gives a concise overview of the medical model and its 'tenets': During the late 1800's Emil Kraeplin became the first to 'clearly articulate the system of assumptions that underlies the field of biological psychiatry and to assert that…'mental disorders are products of a diseased brain'. Based on theoretical speculation and clinical work Kraeplin concluded that psychiatric disorders - like physical illnesses- are discrete entities with distinct physiological causes (Hence future obsessions with women's physiology and mental deviance). From this point psychiatry – Williams' notes – becomes a field which gains political power that has generally been considered the highest authority in the field of mental health (2012:14). The Principals of the medical model (Stated by Klerman, 1978) –that lie at the foundation of the dominant paradigm in mental health are documented by Williams (2012:15) as follows:

- Psychiatry is a branch of medicine
- It should use modern scientific methodologies and base its practice on scientific knowledge
- Treats people who are sick and who require treatment for mental illness
- There is a boundary between the normal and the sick
- It is the task of psychiatry, as of other medical specialties, to investigate the causes, diagnosis and treatment of mental illnesses
- The focus of psychiatry should be on the biological aspects of mental illness
- There should be an explicit and intentional concern with diagnosis and classification…

Williams work provides a summary of how science, history and personal narratives of recovery are evidence of a system that both damaging and lacking in any hopeful alternatives or that recovery is either possible or common.

Shorter's *History of Psychiatry* (1997) proffers an imaginative summary of the history of mental illness:

'*First there were those wicked biological psychiatrists in the nineteenth century, and then psychoanalysts and psychotherapists came along to defeat the biological zealots*'.

Shorter's work aptly tracks changes within the mental health system as a 'social history' rather than an 'arid' succession of theories and concepts. Historical excavations reveal the undeserved treatment of those presenting with symptoms of mental illness. These are referred to by Shorter as the' locking into asylums those who otherwise would be challenging the established order', a practice deemed by psychiatrists as the representation (the asylums) of 'undiluted progress in the alleviation of human misery' (1997). Contemporary research has done a beneficial job in contesting this notion proving that rather than alleviating 'misery' the practice of confinement of those who were diagnosed as mentally ill had quite the opposite effect. In writing about her experiences of a first – and last- admission to a psychiatric hospital in 1993, author Jacqui Dillon's words fittingly summarise the narratives of women's personal experiences of psychiatry that were included in the literature review:

"I knew then, and I still know now, that to be in such an unsafe environment was potentially lethal. Ironically, the place that was meant to provide sanctuary for me became the place that nearly drove me over the edge"

*(*Rapley, *et al* 2011:145).

Literary analysis exposes the continuation of oppressive institutionalisation of women despite political claims to the contrary. It also exposes the nature of society's response to emotional distress and the treatment of women within the institutions and asylums that evolved during the nineteenth century; the asylums that were the '*linchpin*' of mental health services -as documented by feminist author Joan Busfield:

"The places where psychiatry clearly emerged as a separate speciality within medicine and where madness was transformed into mental illness"

(Busfield, J 1996:123).

Medicalising Women's Experiences of Distress

"Looking for causes in brains and minds and not in people's lives"

(Rapley, M *et al* 2011:29)

The following excerpt has been taken from the literature in an attempt to illustrate the overall way in which women's mental distress is medicalised (via psychiatry/biomedical care). Stoppard and McMullen in their study of Women's depression in a social context note that:

"When a depressed woman seeks medical attention and is diagnosed with depression, her depressive experiences are legitimized as symptoms of an illness and given a medical label…In the diagnostic process, health professionals abstract limited aspects of a patient's experience from her ongoing life circumstance and label them as "symptoms"".

(2003:3)

In contrast to the above diagnostic process Doctors Corry and Tubridy (2005 & 2007) maintain the appreciation of symptoms of mental distress –such as depression- as being 'normal human reactions to abnormal situations'. The same author notes that the prevailing medical view of symptoms of distress is to 'remove them speedily and efficiently so that the status-quo returns' (2007:74). Tubridy proposes that these symptoms act as messengers and serve the purpose of alerting the person to underlying causes. In this argument the valid

notion presented is that these symptoms must not be ignored or 'anaesthetised' – such is the more socially validated way via psychiatric interventions and the prescription of sedative drugs.

This viewpoint challenges predominant medical practices and advocates for the incorporation of a more holistic approach to mental health treatment emphasising recovery based practices and the use of psychotherapeutic interventions. The rationale for this emphasis on moving away from medical and psychiatric viewpoints is – according to Tubridy- largely due to the fact that emotional symptoms – in order to be recognisable to the medical profession- have to be 'translated' into medical symptoms or 'encoded in their language' thus losing their function in the process (2007:75).

Recovery

"Recovery is described as a transformative process as opposed to merely achieving stabilization or returning to baseline"

(Deegan, P, 2001:5)

Sharing her personal experience of diagnosis and recovery, Deegan (2001) writes of her experiences of emotional distress at aged seventeen that were eventually 'labelled as mental illness'. She described being diagnosed with schizophrenia as:

"Before being diagnosed I was seen as a whole person, after…it was as if professionals put on a pair of distorted glasses through which they viewed me as fundamentally ill and broken… the psychiatrist did not give me a diagnosis. He gave me a prognosis of doom…the best I could hope for was to cope and remain on medications for the rest of my life"

(2001:8-10).

Reform of mental health services incorporates a more humane service than the psychiatric models. The recovery ethos is one that takes individual *strength*, *resourcefulness* and *experience* into account. The mental health reform "believes that realising the recovery ethos is central to achieving reform of mental health services" (2013:2). A fundamental part of this recovery is documented in both the key mental health policy A Vision for Change (2006 report) and the MHR (2013) publication as inclusion rather than the traditionally stigmatising and isolating way in which psychiatric diagnoses affected people.

"One of the fundamental principals in this report is 'recovery', in the sense that individuals can reclaim their lives to their best extent and be involved in society – to be socially included"

(AVFC, 2006:41 in MHR, 2013:3)

Through 'angry indignation' the author describes her rejection of this life sentence that held no hope for recovery, and her subsequent transformative experience of recovery that sees her name and not a diagnosis at the centre of her being;

"Recovery is not about going back to who we were. It is a process of becoming new…Transformation, rather than restoration, becomes our path…people are more than their diagnoses. People diagnosed with mental illness are resilient…more than passive victims of disease processes. There is hope for recovery."

(Deegan, 2001:18).

Women, Homelessness and Mental Health:

"To know why I am here is to understand who I am and to know a little bit about my story"

(Bledsoe, C, 2001:23-42)

Mental distress is not something that occurs in isolation; as mentioned earlier (Morrow & Chappell, 1999) women's mental health cannot be understood in isolation from the social conditions of their lives. Though the experience of homelessness may not be the underlying cause of mental distress or vice-versa, it is in keeping with the ethics of a humanistic and feminist perspective to recognise this as a significant factor in the lives of the women with whom this research is being carried out.

The Women's Health Council stress that 'mental illness' can be a cause as much as a consequence of homelessness; it also states that patients leaving mental health institutions have been found to be at a high risk of homelessness and that services for this group are deficient (WHC,2005:69).

This section discusses previous research that addresses women's homelessness. It draws parallels between the life experiences that impact on both women's homelessness and mental distress and recovery. Qualitative findings from an investigation of homelessness among women in Dublin (Mayock & Sheridan, 2012) report that:

"*Of those who first experienced homelessness between the ages of 18 and 25; these women tended to have longer histories of homelessness and more complex needs (than those who became homeless in later life), related, in many cases to traumatic childhoods, drug and alcohol misuse and mental health issues"*[8].

The discussion seeks to outline the diverse nature of women's homelessness (which differs to that of men's experience and therefore challenges traditional views on homelessness as a predominantly male issue). The following presents an overall picture of women's homelessness in Ireland and concentrates mainly on the studies carried out in the two main city areas of Dublin and Cork. Included is an indication of the prevalence of women's homelessness in Ireland, and most relevant to this research – the intersection between women's homelessness and women's mental health. It is noteworthy at this point to highlight the problem of accuracy and statistics as studies have shown that the nature of female homelessness is a 'hidden' one, leaving women less likely to be included in research or counted in surveys.

Women's Homelessness & Mental Health in Ireland:

For the purpose of this research the subject area has been narrowed down to studies carried out in Ireland which in itself is a challenge as it is difficult to try and identify the needs of a group who remain less visible both in terms of the nature of their experiences and their priority on political agenda. The participants accessing the Good Shepherd Aftercare service are based in the city area of Cork as is much of the recent qualitative and quantitative information gathered in the context of homelessness (Good Shepherd & Cork Simon Community 2011, Mayock & Sheridan 2012); this makes relevant the use of the studies referred to in the literature review as it may represent a relatively accurate profile of the women involved in this study.

[8] Alcohol and Drug Research Newsletter: Issue 42, summer 2012, p. 10-11 *Findings from a study of homeless women in Ireland.* http://www.drugsandalcohol.ie/17688

'Counted-in': Homelessness, Women & Visibility

In 1985 the first Irish study dedicated to women and homelessness (Dublin) was written by Sister S. Kennedy, the objectives of which were to identify the circumstances of 'hidden' homeless[9] women in Dublin City. The findings of this research revealed that the primary reasons for (or pathways to) homelessness were severe family disruption, violence in the home (including rape and incest) and pregnancy outside of marriage. The study concluded that given the nature of its characteristics women's homelessness remained hidden or less visible in research:

> *"Homeless women are less likely to be counted in surveys of the homeless because of the lack of adequate facilities for them and their tendencies to double up with friends or family rather than approach homeless shelters"*
>
> *(Kennedy, 1985:72).*

Counted In – Women & Visibility in Research:

The next Irish study uncovered during the literature search was an article published in the *Irish Journal of Applied Social Studies* in 2000[10]. Authors Norris and Kearns focus on social policy and the lack of research that its reform was based upon. The article describes a study of the first detailed survey of the homeless population of Cork city which intended to address the 'dearth of empirical evidence on homelessness in Ireland' (2000:61). Though not explicitly feminist it is relevant to this research as the article tracks the changing socio-economic profile of homeless people to include women and children. The research concludes that traditionally homelessness was viewed as an issue largely affecting men:

> *"Presented as a relatively homogenous group in terms of gender…the stereotypical 'homeless person' is described as a middle-aged, single, unemployed male".*

[9] Hidden homelessness describes those who are homeless but do not often use sheltered accommodation. This group of women find alternative shelter with friends or family and can also include those in prison, rehabilitation, hospital or psychiatric services.

[10] Norris, Michelle and Kearns, Noreen (2000) *The Changing structure of the homeless population in Cork city: Implications for theories of homelessness and service provision*. *Irish Journal of Applied Social Studies*: Vol.2 Iss. 2, Article 4, pp. 61-83. http://arrow.dit.ie/ijass/vol2/iss2/4 sourced 06/03/2013

The same publication found that findings of contemporary studies have now challenged this viewpoint (*ibid: 78)* with more women and children constituting this group. The research of Norris & Kearns found that during the survey period of one week (April, 1999) of the 237 adults identifying as homeless, approximately 54 were women. Several authors (Norris & Kearns, 2000, Baptista, , Kennedy, 1985) indicate that statistically women are being represented in higher numbers but these can be inaccurate due to the nature of women's experiences of homelessness; women (especially those with children) are less likely to use emergency shelters or institutional accommodation, usually doubling up with friends or family thus making them less visible in research. It has been estimated that women with dependent children constitute one of the fastest growing subgroups in the homeless population across Europe (Norris & Kearns, 2000:68).

Tracking Changes:

Recent findings from services providing support and sheltered accommodation to women who are homeless in the Cork area[11] indicate accuracy in the predictions of the Norris & Kearns Study. Bearing in mind the difficulties in measuring prevalence rates, the following data provides evidence of the growing number of homeless women:

- The GSS (2011) records a total of 515 women who have received assistance from their service during that year. The number of women in the emergency shelter was 344 (446 including children), 171 women were supported by the aftercare service (204 including children).

- The GSS and Cork Simon Community are two voluntary agencies supporting homeless people in the cork area (Cork Simon supports both males and females). During the second week of July 2011 both of these agencies undertook a 'snapshot study'[12] of those using their services in an effort to 'document the health and related needs of people using their services'. During this week 115 women were supported (52% of women had a diagnosed mental health condition).

[11] Good Shepherd Services & The Cork Simon Community.
[12] Good Shepherd Services & Cork Simon (2011). *Women's Health and Homelessness In Cork.*

Where are we now?

In 2012 a research paper by Mayock & Sheridan presented findings from a qualitative study of homelessness among women in Dublin, Cork and Galway. One of the methods employed by the researchers was life-history interviews with 60 women aged between 18-62 years. The paper focuses on women's 'journeys' into homelessness and reflects the methodological ethos of feminist research thus justifying the use of its findings in the literature review as an true portrayal of women's experiences. The findings are emphasized here in support of this study's attempt to illustrate the existing parallels between homelessness, gender and mental health.

In keeping with the findings of Sr. Kennedy's 1985 study, the 2012 Mayock & Sheridan research found that large numbers of women were still spending periods of time in 'hidden' homeless situations; this serves to conceal women from both homeless services and statistical counts. According to the research findings of Mayock & Sheridan Pathways to homelessness included:

- Violence & Abuse during childhood – 43 women reported having experienced some form of abuse or violence as children. Almost half of the women interviewed in the SAVI Report (2002) had suffered some form of sexual violence in their lifetime. 14 of these women (out of 49) said that this either caused or significantly contributed to their becoming homeless (SAVI, 2002:191). The Women's health council (2005:15) states that stressful life events and trauma such as sexual abuse can cause serious physical and mental health repercussions.

- Histories of state care.

- Substance abuse & Misuse.

- Mental Health – 18 women were currently using medication for depression with a further 20 reporting that they had been prescribed such medication in the past; 15 had spent time in a psychiatric hospital.

- Half of the women interviewed reported multiple episodes of homelessness, the triggers for which included '*the transition from institutional settings such as places of detention, psychiatric hospitals or state care facilities*'.

Homeless Women's Mental Health: Social policy & Health Strategy in Ireland

The main findings in relation to homeless women's representation in mental health were found in publications by the DoHC & The Women's Health Council (WHC, 2005) *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision* and the National Women's Council of Ireland (NWCI, 2006b) *Women's Health in Ireland: Meeting International Standards.* As both bodies frequently feature in the thesis it is only fitting to describe their nature and function of their research so as to provide a context to their relevance to this study. This is done against the background of the key policies for mental health care in Ireland.

The Women's Health Council:

"is a statutory body established in 1997 to advise the minister for health and children on all aspects of women's health…The mission of the Women's health council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland"

The work of the women's health council is guided by three principals:

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

(WHC,2005:2).

The findings of the literature review and an analysis of mental health strategy and policy documents reiterate the sentiments expressed in the WHC publication: That gender sensitivity (or homelessness) is not taken into account by the stakeholders in mental health care service. The reasons for this gender neutrality given within the WHC (2005) document are due to the negligence of including psychosocial aspects in treatment and diagnosis and the over-reliance on psychiatry.

The National Women's Council of Ireland (NWCI):

"is a non-governmental organisation representing women's groups in Ireland…working as a national representative organisation of women…(its') mission is to achieve women's equality, empowering women to work together, while recognising difference, in order to remove structural, political, economic, social/cultural and affective inequalities" (2006a).

The NWCI response paper recognises that:

"Women have a particular experience of mental ill health, and therefore specific mental health needs" (*ibid).*

The NWCI "*considers the health of women in Ireland from a feminist perspective*" (2006b), highlighting unequal social and economic status and its' relationship to the health care and resources that women receive. The July 2006 (b) paper was produced in order to 'influence policy and offer ways forward in developing a health service that meets the interests and needs in Ireland' (ibid, 3).

The NWCI:

"*advocates a right-based approach to women's health…services based on the individual's right to dignity, respect and self-determination*' , one of its key recommendations is an '*investment in research to bridge knowledge gaps and inform policy" (ibid, 6).*

Mental Health Strategy & Policy: The Case for Gender Sensitivity

"Better, perhaps, different coats to clothe the children than a single splendid tent in which they all shiver"

(Goffman, 1991:11).

An exploration of mental health strategy and policies in Ireland (for example: The policy document '*Quality and Fairness – A Health System for you' (*2001), AVision for Change, 2006) concurs with estimations that despite recommendations and calls by women's groups for a gendered response in mental health service, no such policy has emerged (NWCI, submission to budget 2011:17). Despite evidence of the need for gender sensitivity in both homelessness and mental health it has emerged that 'in some areas mental health from a gender perspective is deteriorating' (WHC, 2005). The Quality and Fairness policy gives little or no treatment specifically to the treatment of female mental health. Burke (*in* Barry, 2008: 58) remarks that there is 'no mention' of women in the section on mental health. The 2001 strategy or the following policy on mental health (AVFC, 2006) does not include references to the gendered nature of mental health, its determinants (such as homelessness, gender-based violence and abuse or poverty).

In 2006 *A Vision for Change* was published and declared as official government policy for the reform of mental health services in Ireland proclaiming to be *enlightened* and *progressive.* The vision- according to the MHR (Guiding a vision for change manifesto) being:

"*A humane, person focused, accessible and responsive service"*

(2012:7).

Nevertheless there is one very large flaw in both *A vision for Change* and the MHR guiding manifesto. Like many other strategies, practice guidelines and policies of their kind they are virtually gender blind. This oversight happens despite the World Health Organisation stating (five years *before* the publication of AVFC) that gender is a determinant of mental health. In addition to this the United Nations *Convention of the Elimination of Discrimination against Women* (CEDAW:2013) stresses that women are 'disproportionally susceptible' to being at risk from mental illness.

From a thorough reading of The MHR Guiding Manifesto there are a mere eight lines (in a forty four page document) loosely referring to the 'gender-blind*'* nature of AVFC (MHR Guiding AVFC manifesto, p.19). It can be concluded that notwithstanding the gendered nature of mental illness, androcentric (that is male as norm) standards tacitly permeate both the aforementioned publications, hence the knock-on effect of failing to recognise gender differentials in the treatment for mental illness. The NWCI has summarised this as:

*"The Historical prevalence of the male-as-norm as the standard in medical research and in health care has meant that women's experience of disease and health has been often denied or ignored. The outcomes (*of which*) can be considered only partial in the sense of being applicable to only part of the population"*

(NWCI, July2006:14:2.3).

The Women's Health Councils' 2005 publication Women's Mental Health: Promoting a Gendered Approach to Policy Service and Provision, alludes to the problematic nature of the absence of differentiated approaches in a health issue that is gendered in both nature and manifestation:

"*Mental health services in Ireland are gender-neutral at best, and skewed towards the needs of the male population at worst*"

(2005:7)

The existence of research practice and service delivery that is not sensitive to gendered experiences raises the basis for feminist research inquiry in this context. The researcher asks how can knowledge that informs social policy and service delivery meet differentiated gender needs when it is in itself, *'at best'* gender-neutral? One could not be legitimately reproached for querying its effectiveness on the recovery of its recipients. To recognise both the gendered nature of health and that of homelessness would result in a more integrated and responsive approach in health policy.

Conclusion

> *"There is a serious dearth of dedicated research of homeless women in Ireland, where it was well over two decades since the publication of the last qualitative study of homeless women"*
>
> *(Mayock & Sheridan 2012:2).*

Echoing that of Sr. Kennedy's findings the above quote taken from the findings of the study carried out in 2012 (Mayock & Sheridan) is indicative of the serious lack of priority given to researching women's experiences of homelessness (and within it their experiences of mental health) in Ireland. Over two decades is a substantial time-span during which the needs of a marginalized and growing group have been neglected. Despite the development (and subsequent demise) of a *'Tiger'* economy a review of the literature in both an Irish and European context reveals a definite 'paucity' in qualitative studies in this area. In a critical review of research undertaken in a European context Isable Baptista[13]notes the almost total absence of comparative European research on women's homelessness.

A considerable gap is apparent in research that looks at the needs of women's homelessness in Ireland (corresponding with international findings that the same gaps exist in other countries). Despite the recognition of a 'considerable gap in gender-specific research' coupled with the rising number of women at risk of homelessness, the literature review carried out by Baptista notes that the most 'striking feature' of research on women's homelessness is the obvious lack of it. This, Baptista suggests, may be due to the typical form of homelessness amongst women being 'hidden' homelessness which does not easily fit with firstly the typical definitions of homelessness. In addition, the perception that this is predominantly a male issue contributes to women's experiences being overlooked.

[13] Baptista, I. Women and Homelessness: *Reflections on Homelessness and Research In Europe.* www.ebscohost.com 06/03/2013

Echoing the findings of the Women's Health Council (2005) and that of Baptista, Martin Keane's conclusion – based on the Mayock & Sheridan study- aptly reflects the challenges facing women who are homeless and experiencing mental health distress. These findings show that it is a field of inquiry that has been overlooked in the past and mental health services for this group are insufficient. The experiences documented by the women in the Mayock & Sheridan study 'paint a vivid picture' (*In*: Keane, 2012:11) of the role that experiences such as poverty, childhood trauma and abuse, family breakdown and addiction play in the lives of the women who were interviewed.

Research (Baptista,1990 *et* al) refers to the need for a focus on studies that take into account the impact of violence, trauma and abuse on women's pathways to homelessness but neglects to include the need for similar studies on the impact of mental health.

Keane concludes that the narratives of these women contain evidence of the lasting influences these issues have on women and the 'inextricable' link in adulthood with homelessness, substance misuse and mental health (Keane, 2011:11). It is 'hoped' Keane finalizes that 'the gender perspective' conveyed in the 2012 Mayock & Sheridan investigation will:

"…*critically inform and influence policy to help to ensure that services work appropriately and effectively to meet the needs of homeless women*"

(Mayock & Sheridan 2012:16 *in* Keane, 2012:11).

Chapter 4 The Research Findings & Data Analysis

Introduction

This chapter presents the findings and analysis of a collation of literature review findings and the experiences of the women interviewed for the thesis through fieldwork carried out during the research. The findings and analysis are based on the responses of the six women who participated in the interviews, and a framework of relevant information and theoretical perspectives gathered during the literature review.

It is imperative to note at this point that the themes emerging from the participants' experiences are separated only for clarity within the data analysis and findings. All of these themes are deeply interconnected and the intrinsic relation to one another and the overall impact on mental well-being should not be underestimated.

All of the women interviewed came from different paths in life: they varied in age, educational experience, parental and marital status. Their experience of mental health services also varied: Some women had been involved in mental health care and/or homeless services on a cyclical basis from a young age, some had only one admission to both psychiatric inpatient units or homeless services. All of the women disclosed diagnosis of depression and violence and abuse. All six women stated a goal of recovery was to be medication free. Again, it should not be underestimated how diverse these experiences can be as each person has their own perspectives and values.

A Note on Consent: The findings are supported using some direct quotes and dialogue from the women who were interviewed. The rationale for using direct quotations from the transcripts is that it is an accurate and valid representation of the original data at the point of collection. It was clearly stated in the interview process that direct quotes would be used to support the research findings. However, as the women did not wish to be named in the report they are referred to as interviews numbered 1-6. Other names and possible identifying details have been changed throughout the text, this is to protect anonymity and to respect the privacy of the participants.

Selecting the Data: The five 'core components' of Recovery

The strategy used to select the most relevant data in this context is based on the five 'core components' of the mental health reform (2013) publication '*Recovery…what you should expect from a good quality mental health service'* (As outlined in the methods).
Using the framework based on these five core components expected as part of a healthy recovery in mental health allows the researcher and participants to identify what strengths there are in services and what they experienced as barriers to effective care. This in turn highlights the gaps in services and identifies where innovation in service delivery is required. This selection process seeks to answer the third question set out by the Good Shepherd services:

"The final phase of the research is to collate all of the information gathered with a view to posing questions to identify what the women believed were the 'ideal models of service' that would meet their needs and also to 'highlight any gaps' in the current services. This final phase seeks to assist the Good Shepherd services in evaluating where innovation in services is necessary in order to develop 'tailored supports to meet our client's specific needs".

As with other feminist, qualitative research methods, reflective interviews span a considerable amount of time and allowed for open discussion resulting in a wealth of constructive information. This amount of data would not be within the remit of this study to include– this would only be possible in a larger study or a possibility for future projects. After the initial analysis there is a section dedicated to the emerging themes the participants shared - those which were outside of the sphere of the data selection framework but which were considered valid factors to draw attention to as they were named in this and other research (Doyle, 2011, Mayock & Sheridan, 2012,The SAVI Report, NWCI, 2005) as leading causes to women becoming homeless and struggling with emotional distress.

The Recovery Model as a Relevant Data Selection criteria for Homeless Women:

"Recovery is a very personal process. Ultimately, each individual will define what recovery means to them"

(MHR, 2013:2)

The literature review brought to light the need for a paradigm shift away from stigmatising and ineffective biomedical models of how we understand mental health, especially as they focus on mental health as a deficiency or impairment and they are gender-blind. Reform of mental health services incorporates a more humane service that takes individual *strength*, *resourcefulness* and *experience* into account. The MHR (2013) document "believes that realising the recovery ethos is central to achieving reform of mental health services" (2013:2). A fundamental part of this recovery is documented in both the key mental health policy A Vision for Change (2006 report) and the MHR (2013) publication as social inclusion:

"One of the fundamental principals in this report is 'recovery', in the sense that individuals can reclaim their lives to their best extent and be involved in society – to be socially included"

(AVFC, 2006:41 in MHR, 2013:3)

The social inclusion aspect of recovery recognises a person's right to meaningful participation in their community and seeks to remove attitudinal and economic barriers to social inclusion, such as stigma and lack of access to suitable housing and education (Department of health and children, 2006: Mental Health Commission, 2005).
The Women interviewed not only are at risk of social exclusion due to their experiences of mental distress but also face the double jeopardy of homelessness: It is an important aspect to be aware of when analysing the research findings as access to safe and secure housing plays a considerable role in their lives. All of the women spoke about adequate, safe housing being a contributory factor in their recovery; unsafe, unsecure and temporary accommodation is not conducive to mental well-being. Understanding the connection between housing and mental health issues "from the perspective of psychiatric survivors" (Forchuk *et al*, 2006:42) is an integral part of recovery orientated services.

The Five 'core components'

Hope: Did the women experience an expectation of hope?

The Mental Health Reform publication states that Mental Health Professionals must convey an expectation of recovery and must demonstrate a belief in the individual's strength's and capacities. This has been a consistent demand of people with experience of mental health difficulties (2013:9).

The women who participated in the interviews had varying experiences of this hope. Two ladies spoke of the positive impact of a hospital admission during crisis points such as suicidal ideation. Two women said psychiatric hospital saved their lives.

"I know they kept me alive – but I'm not sure they were doing much to help…I don't think it's a place for people with eating disorders anyway"

(Interview 5)

One person's encounter did convey an initial lack of hope from her family which she attributed to lack of understanding:

"for me actually it was a good experience, there are so many people who think it is a disaster of a place (the psychiatric unit)…the mention of the place and people are like 'oh my god'….my brother expected to see me in a strait jacket basically and there I was walking out to him talking just like I am to you know…he was in shock…people don't know what to expect" (Interview 1)

When asked if psychiatric hospital admissions were helpful or not some of the responses were as follows:

"It used to help me in the past, brighten me up and feel hope…"

(Interview 2)

"But when I left (hospital) I felt that the psychiatric system just cut me out like, I was just out there on my own…I was angry at them for it…"

(Interview 6)

The MHR publication and narratives of service users that were unearthed during the literature review (Deegan, P, 2001. Barnes & Bowl, 2001 & Bledsoe, C, 2001), have voiced the opinion that hopeful attitudes of the mental health professionals and families or support networks have helped them to recover. The MHR documents this sentiment as the conveying of hope meaning a "positive expectation about the future and expressing belief in the individual's capacity to lead a fulfilling life…. It includes focusing on the person's strengths rather than their deficits…" (MHR, 2013:9).

Collectively, the women did not convey an experience of overall hope for recovery during their encounters with psychiatric hospitals. Although they did express an appreciation of the respite in times of crises, where they could no longer cope alone, there was not a sense of the expectation of recovery from psychiatric service, rather that of a maintenance approach.

"They drive me crazy! All they ask is what's your mood between 1-10, are you smoking, are you self-harming…that's it then, you're gone after five minutes."

(Interview 6).

The responses sadly echoed both the researcher's own experiences and those of many of the service user orientated publications in the literature review: that medical approaches to human distress focused mainly on incapacity and maintaining an absence of symptoms. This appears to have done little for the hope the women felt in relation to their recovery, serving only to exacerbate misunderstanding and stigma. The response of one participant sadly resonated with the experiences of oppression and hopelessness women endure as an extra obstacle to recovering well-being:

"My siblings have nothing to do with me really, lost all respect, I'm the family looper you know…history of childhood abuse…a typical story"

(Interview 2)

Traditionally, women with mental health diagnoses have been brutally stigmatised and oppressed: The findings of the literature review (Ussher, 2011, J, Busfield, 1996, Jones, 1993, NWCI, 2005 *et al)* concur with this. A lack of understanding has shown to be a contributory factor in stigma surrounding mental health (Cullen, 2012). The fieldwork process identified several supports that offered web-based information for service users and family members which was notably focused on medical diagnoses. This source of information and others –

such as leaflets in hospital waiting rooms, GP Surgeries and community health clinics – had an apparent absence of focus on the possibility or hope toward recovery. It is challenging to experience hope when it is not a message reflected in the attitudes of those around you. The strength and resilience of the women interviewed cannot be underestimated despite the absence of hopefulness in recovery.

One feature of the women's experience that *did* offer some hope was their connection with support services outside of the psychiatric base, such as personal development and training and further education. These support services seemed to be more aware of the need to work from a person centred and strengths based approach.

"When they offered me a place on the self-esteem and art course I jumped at the chance and it was fantastic, it really was"

(Interview 1)

"I had a little gardening job…it was a gardening course but there was no pressure…it was heaven up there"

(Interview 3)

Listening: Did the Women feel that they were listened to?

Mental health professionals must listen to service users with attentiveness: This involves three aspects:

1. Listening to the individual's personal understanding of their condition. It is important to acknowledge and respect the individual's own understanding of their experiences:
2. Listening to the individual's aspirations and goals for life…individual recovery planning is designed around life goals: and
3. Listening to the individual's own knowledge about what helps them to recover and stay well.

(Adapted from MHR, 2013:10).

From an analysis of the interview transcripts, there did not seem to be a strong sense that the women were being listened to by mental health professionals within the inpatient hospital or psychiatric outpatient clinics. Each person was asked if they felt listened to and if staff were approachable, however none of the responses were positive when asked about approaching the psychiatrist and not always positive when it was nursing staff. The following excerpt reflects the overall attitude of the respondents

"I hate the fact that psychiatrists are coming in reading from books, they have no experience and are just giving you medication…but you're the one that has been through it, you are the one that knows yourself….most of them don't listen anyway"

(Interview 5)

The views expressed by the women are cause for great concern. None of them felt that they could say to the psychiatrist that they would like to discontinue certain treatments *"She (psychiatrist) would kill me".* Two had attempted to withdraw from medication with no professional support as they were afraid they would be told not to discontinue medication, this can be quite dangerous as withdrawal symptoms are very hazardous. This overlaps with the question of partnership and choice as the women did not seem to be able to exercise any level of choice or control when it came to medical treatment. The same could be said of accessing services:

"I've been asking them for ages to refer me to another outpatient clinic…they said I'd have to change psychiatrist and I said I'd do it but they were like, no, we'll leave it this way. Like – I want to come off medication and they are saying no, you're not ready… I'm on medication the last twenty years!"

(Interview 6)

It became apparent that listening was an issue for due consideration as it obviously presents a challenge for the medical professionals involved. Further training and development is an obvious need in this area, especially as the women were trying to withdraw from medication themselves with little or no professional support. Being 'free' of medication was named by all of the women as a goal in recovery yet clearly it was not respected as being so by support services. The fieldwork process also identified that there seemed little by way of support or information regarding the withdrawal and what to expect when reducing medication.

Another concern that arose was the lack of consideration given to service-users when they said they were not happy with their treatment –they seemed to have been 'told' rather than discussed with what care plans involved, none of them felt able to question this.

"I'm the type of person that will go on what a professional says because I'm after growing up with it, so what they say must be right you know?"

(Interview 5)

Partnership:

The MHR publication states that partnership entails working with service –users as equal partners in their own care which is essential to redressing the traditional power imbalance between service – users and professional. A recovery orientated approach demands equality between mental health staff and service users (MHR 2013:10).

All of the women who participated in the interviews were asked if they would like to have more input in how mental health services were being delivered to them, and if they thought it would improve them. All of the women agreed that this would be helpful

"If they stopped dismissing us just because we have a mental illness, I don't know about you but I'm still an intelligent person, I read a lot…don't treat me like I'm stupid"

(Interviewee 2)

As is apparent that being listened to was a challenging part of the women's experiences. The traditional power imbalances that have permeated biomedical responses to mental health care are still quite evident. The participants were keen to participate more in their recovery care plan. It was obvious that they felt they knew what was best for them but experienced frustration and lack of regard when they tried to participate in their own recovery.

On a positive note: Three of the women did gain from community support services they were referred to as part of their aftercare – plan. All of the women felt that the services provided by the GSS staff helped them to work on their existing strengths and participating in their own recovery. The GSS and further training and advocacy groups were identified as being more beneficial in the longer term sustenance of mental well-being (in turn, impacting on the retention of safe housing). These services were the only area in which partnership seemed apparent.

Choice:

Service users must be offered choices – of treatments and therapies, of who provides their care, of when and where the supports are provided. In the absence of choices between alternative types of treatment, people are essentially denied their right to make decisions over their own mental health care (MHR, 2013:11).

Some points relating to choice have been touched upon in the sections on listening and partnership. Again it cannot be underestimated how much these themes are intertwined. It is important to mention in this section, the relationship between choosing where you live as it was something that emerged during the research process. Having a place where you feel happy, comfortable and safe was identified by the women as being a contributory factor to mental well-being. Unfortunately, as with mental health services, the women were give no choice at all regarding where they choose to live or their treatment – such as care planning, medication or support service referral. The quotes taken from the transcripts speak volumes about the appalling lack of choice these women have over their own lives: One woman spoke of her experience of being admitted to the crisis psychiatric unit and the nurses' response:

"I can help you or you can lie down and die"

(Interview 3)

"the house was a dive, it was really bad, I only took it because I was in Edel house and I wanted to get out of there, they want to get you out as fast as they can too…the nurses in the hospital pinned me down and gave me an injection to knock me out, that gave me a fright…after that when I woke up I knew I had no choice but to stay"

(Interview 4)

"I knew nothing, the GP referred me down there…I didn't know what to expect to be honest, I had no idea what It was gonna be like…it was part of the agreement for my release but I had no problem with it because they were lovely"

(Interview 1)

It could be concluded that this is a rather dismal picture of the level of respect given to an individual's choices in their own health care. The researcher did ask at certain points if the respondents felt they could make that choice relating to mental health care. The women spoke of how times of severe distress were difficult and it is not always easy to make the right choices in the beginning but that having no say at all did not feel like it helped them. One woman's experience illustrates the way in which mental health services don't recognise the progress towards recovery and the possibility of gaining ability to participate in decisions regarding care:

" I lost a lot of memories when I was committed, they could do whatever they wanted really, I wasn't happy about it and I wouldn't have agreed to it if I had been compos mentis…my husband signed for it (Electro-convulsive-therapy)… I had no say there and no say with the other ten sessions I got after that… but then I was able to say no"

(Interview 2)

None of the women got much choice regarding housing which they attributed to low income. This left them exposed to unsafe experiences, particularly with what one interviewee described as 'creepy' landlords and overpriced, poor quality housing in unsafe areas.

Social inclusion:

The importance of social inclusion has been touched on in the opening paragraphs of this chapter. Itis revisited here in order to link the importance of choice and partnership in housing, healthcare and education, and it's relevance to emotional well-being.

Mental health services have an important role to play in supporting people with a mental health difficulty to participate in their own community, have social relationships and engage in meaningful activities including education and employment. This includes helping those at risk of homelessness to secure housing. In this way community mental health teams become a bridge between mental health services and mainstream community supports (MHR, 2013:12).

"I got my own little one bed-roomed bungalow…I never thought I would see the day – thank God everything is coming together because I thought I would be in and out of flats forever. I'm hoping to start a course as well with focus…it has all come together"

(Interview 6)

Social inclusion played a large part in the women's experiences of mental distress and recovery. Many of them named isolation as a contributing factor to the breakdown of their well-being although this was often something triggered by abusive situations and poverty.

"If you are socially isolated that is a big thing with depression. That you are not going to get yourself out of it, you need to push yourself and get involved with things that are going on"

(Interview 1)

The aspect of social inclusion was the area in which the data analysis demonstrated most positive feedback. Although housing was quite a concern in terms of access, quality and retention, other aspects gave indication of hope. Despite the difficulty of having experienced mental distress these women were able to find a social solidarity in the community services that benefitted their well-being. All of the women had accessed education and training and development through community care service and the Good shepherd Aftercare service. All of the women said they 'would be lost' without the after-care workers in the Good Shepherd Service. This validates the point of 'bridging the gap' between mental health and community services and highlights the importance of specialist training in the area of mental health and recovery for staff of community and voluntary based provision

What is good about services?

The women spoke of the inequality and unfairness with which they were treated in some psychiatric services. There were also times where they found strength and resilience, some learned from the experiences ways in which they could change and grow. The comment below illustrates the ability these women had in finding gifts among thorns:

"What was the most helpful thing that you can think of, that they gave you in hospital?

...they gave me my best friend… they gave me (name)"

(Interviewee 2)

As already mentioned, The Good Shepherd Aftercare staff seemed to be a very positive link between psychiatric hospital stays, being discharged and returning to safe housing.

"I am really good today and I really put it down to the help I have gotten from … (aftercare worker) when I came out of hospital and my memory was just brutal, even to bring her along to meetings was fantastic because she would remember what was said….

(Interviewee 1)

Having a secure and safe access to housing is an integral part of recovery and staying well, aftercare workers play a vital role in this as they help with access to housing and information.

Other supports identified as being of benefit included access to parenting programmes, training and development and education. In a holistic sense, the women have benefitted from aftercare services as it has contributed to their overall recovery, their sense of self and the links the services provided with other community based supports which in turn combat isolation and facilitate steps towards social inclusion.

Having a good GP 'who understands' and people who are supportive were all identified as helping to recover and stay recovered from mental health problems.

Barriers to recovery:

During the research process barriers to recovery were identified as:

***Time Limits*:** Imposing time limits on how long services are available:

"It's difficult to be told you have to get it together in three months…."

(Interview 1).

Is there a sell-by date for pain and distress? Is it fair to impose a limit on intervention or support services? The sentiments echoed by the interviews correspond with some of the literature review findings: you cannot put a time limit human pain. Distress is an inevitable fact of life and biomedical responses to it are ineffective in that they impose time limits regarding intervention services.

An over-reliance on medication: In concurrence with the literature findings and those highlighted as barriers by social policy & health strategy documents, the women interviewed identified medication (and its side effects) or being over-medicated as a barrier to recovery.

Many felt that they had no input into decisions made regarding this. All of them named being 'free' of medication as a long-term goal with or without the support of their prescribing practitioner.

***A lack of understanding by family*:** This manifested itself mostly in misunderstandings of mental distress and what to expect. Many of the interviewees were isolated from their families for this reason. Information given to families by support services – particularly web-based –is medical/psychiatric information is extremely vague and does not put an emphasis on recovery.

Waiting lists and inability to access counselling services due to financial restraints were also named as barriers to recovery. It also transpired that some women can disengage with services for a period of time, or transfer to another catchment area which results in them losing their places on lists and having to start again.

***Access to housing and welfare*:** Losing rent allowance while in hospital was named as an issue which could be addressed by a greater awareness in welfare services of the importance of having a home.

Support with withdrawing from medication: From the researchers' personal experience and from literature review findings, it is not recommended to attempt to withdraw from psychiatric medication without the support of a medical practitioner. None of the women interviewed mentioned that they had support with this and were unclear about where they could find it. Further researcher shows that psychiatrists and general practitioners have little information regarding this issue (Breggin, 2013).

Cultural Diversity: One of the women interviewed raised an interesting point in relation to cultural issues on how women were treated in mental health services. This person highlighted the problems that can occur with psychiatrists or nurses who are male and come from cultures or religious orientations where women are not held in high regard. The interviewee felt that this resulted in experiences of being treated dismissively.

Subsidiary Themes that Emerged During the Data Analysis

The nature of the interviewing method allowed for some very insightful discussions between the researcher and the women who offered their time to contribute their narratives. As stressed earlier on in the chapter, this culminated in an extensive amount of information, not

all of which it was possible to include in a smaller scale study (such is the limitation of the chosen method of inquiry). The transcripts were analysed in synchrony with the five components of a recovery-based service. As is the nature of the human experience, not everything can put neatly under headings and subheadings. Feminist epistemologies and research methods appreciate this fact and the diversity of the experiences of the women involved in this study.

However, several themes recurred throughout the literature search and the interviews that the findings would not be valid without mentioning. Childhood trauma, abuse and neglect, as well as gender-based violence in adulthood were all identified by the women s contributing factors in their experiences of mental distress *and* homelessness. This concurs with other research in Ireland – especially the SAVI Report which has given an entire chapter of its document to gender based violence and mental health among homeless women. The women interviewed did not feel that these were taken into consideration by mental health services as being part of their distress, none of them had experiences of these being addressed by psychiatric services but needed to be (addressed?). At best, the women were advised to seek counselling to address these distressing issues but again, unrealistic fees for psychotherapy and counselling service prevented them from doing so.

Conclusion

What was most striking during the interviews was the lack of a sense of entitlement the women conveyed. There was certainly a huge sense of strength and resilience but regretfully, this seemed to be something they needed to hold on tight and fight for within a system that claims to be health and recovery-orientated. It could not be overlooked that powerlessness played a significant role in how mental health services were experienced – which reflects the sentiments offered by the theorists that have been reviewed for this research.

At no point in time did any of the respondents suggest that they had been asked to "define what recovery means to them" (MHR, 2013:2). Clearly there is a greater need for a humane service that listens to the service user – as is indicated by the MHR 2013 publication, the NWCI and the Women's health council (2005). The themes of powerlessness, a lack of dignity and worth and partnership permeated the data analysis. The conclusion that has been reached is that the expectations the women interviewed had of psychiatric services were quite

limited and there is considerable awareness of the gendered aspect to be raised in this area. In addition there is a need for mental health policy and women's homelessness strategies to be integrated due to the overlap between mental well-being and safe housing.

It is fair to contemplate that the MHR (2013) Publication is a new development and may need some time to be implemented. It is a welcome consequence that there were some positives relating to this strategy and the research – social inclusion is a significant challenge to women who experience gender-based violence, poverty, marginalisation and homelessness.

A significant finding closely related to the central values of the methodology was that all of the women identified with the ethos and values of feminist research. All were asked if they felt that women's needs needed to be specifically addressed within mental health care and all of them responded that yes, they were. Two people highlighted the fact that psychiatric units can feel unsafe and volatile places for women to be. All six of them agreed that 'having their say' would help improve services.

"How do you feel about your experiences being used as part of the research?

I have no problem about being open because in order for others to talk the stronger ones need to lead the way…"

Chapter 5: Recommendations & Conclusions

Introduction

This final chapter will present a summary of the main findings of the research with an evaluation of how these findings contribute to answering the research questions outlined in the introduction. It will outline the potential for the use of feminist research in implementing recovery orientated mental health services for homeless women. It will also include the recommendations interviewees made during the discussions in relation to changes they would like to see happening in mental health care.

Evaluating the Women's Experiences using the MHR Recovery Ethos: The five key building blocks of a recovery approach.

Using this section of the MHR 'roadmap for recovery orientated services' (2013:2) as an evaluation strategy was beneficial as a guide to answering the questions set out by the Good Shepherd services. The framework offered by the MHR paper helps to answer specific questions such as:

- What the clients of the Good Shepherds Services found helpful about the mental health support services they had accessed, what helped them to recover.
- What was not so helpful about services.
- What barriers prevented clients from using services.
- What services clients found beneficial and why.
- The MHR framework also allowed the researcher to identify where the gaps in recovery orientated service provision were, and to identify what the innovation needed for better support and recovery would look like. These concurred with the recommendations made in the MHR papers' chapter on Implementing recovery orientated mental health services (2013:15-25).

There was a large quantity of information gathered in the interview process. The five core components of recovery (Hope, Choice, Listening, Partnership & Social inclusion) were useful as a method through which this information could be selected and segmented. The researcher particularly welcomes that this paper - the 'roadmap' for recovery orientated services - developed during the time in which the research was taking place as it allowed for the opportunity to consider innovative ways in which mental health research is carried out. This also reflects the CARL initiative in that this study has used current developments - such

as the MHR recovery approach- to research the needs of a community organization.
The current direction in mental health care in Ireland (although still not gender sensitive) has shifted away from oppressive biomedical paradigms of care that focused on deficiency and symptom of 'illness'. Mental health reform groups and other research have called for a paradigm shift away from biomedical models of care towards a recovery orientated service (Bledsoe, 2001., Barnes & Bowl, 2001., Morris, 2010., NWCI, 2005., Philips, 2006., Pilgrim, 2009., Ryan *et al*, 2012). The MHR 2013 paper describes this concept of recovery and acts as the 'roadmap' for implementing recovery paradigms in mental health care in Ireland. It is based on other research from relevant stakeholders – such as the service-users, the mental health commission (Higgins, 2008., Byrne & Onyett, 2010) , the expert group on mental health policy in Ireland (2006), consultation groups and policy makers.
The Good Shepherd Services did not explicitly indicate a recovery orientated perspective as being part of the research perspective. This is an interesting observation and one that needs to have attention drawn to it as the researcher believes that it is part of the innovation in service delivery to name recovery as part of any mental health support service. The GSS aftercare service was found to have been a considerable support to the women interviewed so it is imperative services like these embrace the concept of recovery.
The research report is submitted to the Good Shepherd Services using the recovery ethos as one of the focal points in the research process (the other is using feminist perspectives to research homeless women's mental health needs). Using recovery principle in this study is compatible with current developments in mental health care policy and service delivery in Ireland. Due to the study being undertaken as a CARL project, it is an opportunity to implement the recovery ethos and to 'bring this ethos to life in the delivery of mental health services' (MHR, 2013:2) , specifically in the context of women's homelessness and mental health support services.

Exploring Homeless Women's Mental Health from A Feminist Perspective – Did it satisfy the research aims?

Research with an explicitly feminist perspective was chosen as the method through which to explore women's homelessness and mental health for the reasons that follow:

- Women's homelessness and Women's mental health are gendered experiences, many aspects of which are exclusively women's issues. Thus, it makes sense to explore these issues from a perspective that recognizes the gendered experience.

- Feminist research delves further into social issues than other traditional methods and looks beyond the conventional androcentric manner in which society understands its own structure. This, the researcher argues is key to bridging the gap in power relations – the marginalized women groups' experiences of powerlessness and the professional patriarchal power projected upon them (in the form of psychiatric care).
- The research needed to be participatory in order to reflect the paradigm change in mental health called by the service user movement. It also needed to represent and interpret women's experiences in an accurate light. This was to be done from the perspective of someone traditionally outside of the research process - a researcher who is also an academic, practitioner and service-user. The ethos and values of feminist research practice reflect both the position from which the researcher was working and the women's position.

The conclusions drawn from the study is that the chosen method succeeded in the "*deconstruction of the power relationship between researcher and researched*" (Byrne & Lentin 2000:4). This in turn led to the women being able to be more open and honest in their discussions which has a knock-on effect in accurate answering of the research questions set out by the GSS

The research identified many issues relating to homelessness and women's mental health: Homelessness and mental health are inextricably linked yet there is a glaring absence, a 'relative paucity' (Baptista, 1990:163) of research being carried out in this area. One of the findings during the literature review was that women's homelessness was not referred to in the current Irish homelessness strategy (The Way Home 2008-2013). Many women experience the loss of accommodation while in psychiatric care which leads to their becoming homeless. The following dialogue from one of the women interviewed in this study reflects the overall nature of how mental health and homelessness are linked:

"Where did you go from there? (hospital)…

…I spent 10-12 weeks there (hospital,) I had nowhere to go…

Did you lose your accommodation while you were in there?

…Yeah, gone. I had nothing. It was through the social worker I got in touch with (GSS)…"

(Interview 3).

Other problems/Barriers identified were:

- An Over-reliance on prescribing medication – the women interviewed and literature review findings expressed the need for choice and change in this practice. This correlates with other research findings (Breggin, 1991., NWCI, 2005) relating to the problematic nature of psychiatry, medicalizing emotional distress and issues of power (Sasz,1961., Rapley, 2011).
- Lack of an acknowledgement of women's homelessness and mental health as an intertwined experience.
- A lack of choice and participation in access to mental health care and support services: types of support, choice relating to medication, choice relating to housing.
- Cultural issues such as fear, stigma and shame leading to the problem of social exclusion and isolation – individuals in distress are frightened and overwhelmed by psychiatric diagnoses they do not feel they can identify with, or that remove their identity as individuals, loss of social roles.
- Structural issues exacerbating the experiences of mental health and homelessness were highlighted as: a lack of choice in housing, poor quality housing, issues with social welfare and finances, location.

Doing Research – What we know & challenging traditional values in knowledge:
This research demonstrates that the strength and ability of women experiencing the double jeopardy homelessness and mental health are evident as lifelines to recovery. It became obvious that these strengths were overlooked by mental health practitioners. Putting mental health (or emotional distress) in the realm of medical practice has meant losing touch with the necessity of connecting with the human experience. It is even more of an issue for women due to subordination within a male-dominated sphere, the historic preoccupation medical science has with medicalising women's bodies (Busfield, 1996, Ussher, 1991 & 2011., Schowalter, 1987 Stoppard & McMullen 2000 & 2003*).* and the loss of gendered social identity. Hence the argument for it as a feminist issue- Irish society places unquestioned faith in medical science which has resulted in the medical and psychiatric profession having a complete and unquestionable monopoly in what is legitimate knowledge in mental health. This is particularly evident in the sphere of psychiatric services and is dangerously open to abuses of professional power. The researcher concludes – with the support of the interviewees- that it is time for this knowledge/power supremacy to be questioned.

Recommendations

As indicated throughout the study there is a pronounced need for change in the way we research marginalized groups, particularly women's groups.
The researcher recommends that more 'women friendly' or gender –sensitive methods of searching for knowledge that informs mental health practice & homelessness be implemented. The information gathered during the interviews and its' invaluable contribution to the research process is evidence of this.

Recommendation For All Services That Support Women Who Experience Mental Distress:

Embrace an awareness of the gendered nature of mental health experiences and the need for a response in a gender-sensitive manner.

Using the Mental Health Reform 'Five Core Components' of a recovery orientated service is recommended for its potential to highlight where innovation and change is necessary (such as gender sensitivity). It is a user-friendly evaluation method that could be applied and beneficial to any health or support service. To give hope, to listen and empower is not a costly endeavor and can only serve the women accessing support in a positive way.
The humanistic values that are clear within it may resonate better with the individuals and groups who need it. One obvious flaw is that like all other health strategies and publications of this kind it is not gender-sensitive and does not give enough attention to the area of homelessness. A recommendation to consider gender-sensitivity in publications such as this is explicit throughout this study and is also a subject that would benefit from further research. The researcher intends to disseminate the findings of this study to relevant organizations in the hope of raising greater awareness of the need for gender-sensitivity in women's homelessness and mental health care for women in Ireland.

Reflective Piece
Researching From the inside out

David Crepaz-Keay is current head of empowerment and social inclusion at the mental health foundation in London, UK. As a service –user narrating his own story as an illustration of effective service-user involvement, he writes:

"*I started life as an economist and statistician. Had I not gone mad at an early age, I may well still be an economist or statistician. I spent my formative years almost equally divided between a traditional English education and being a traditional English mental patient… by the time I left psychiatric hospital, I has six diagnoses…and had been told not to expect too much from life.*"

(*in* Ryan, Ramon & Greacen, 2012:146).

This thesis grew out of an experience of what the world we live in calls madness. My own dance with this fear-invoking subdivision of life is not too dissimilar to that of Crepaz-Keay; I have as many qualifications as I have diagnoses and, depending on who I am introduced to you by, I am either stark-raving-mad-don't believe-a-word-she-says (mad people are deeply distrustful) or, I am an educated and capable person. Living between these equally crazy worlds, I somehow became a social-worker but was saved from the fate of working statutory services because I went mad. Again, so I became a service-user instead.

Another brush with psychiatry, or people trained by psychiatrists, or both, and a G.P who claimed that I was having delusions (I was afraid of the person who horribly abused me my entire life – a delusion or a natural response?) I was told I could be on medication for the rest of my life. I was asked what I thought of my 'behaviour' in admonishing tones by someone who didn't appear to understand a rape survivor's anxiety at being in a residential centre full of only males – not even a female staff on duty: all at the princely sum of over twenty thousand euro. As dedicated as ever to activism and driven mad by an overwhelming sense of injustice at the way I was treated and 'muzzled' by those who needed me to be quiet lest they end up in prison – I was compelled to become involved in women's mental health.

Doing the research meant that I was reengaging with services from a dual perspective, and while using my position as a way of empowering others, I was also mindful of the need to maintain boundaries to some degree. This was a challenge, it is emotionally hard to sit in front of others people and listen to their stories of being so alone, so distressed but sometimes too so strong. I was really moved by the women's enthusiasm to be a part of the research and so hopeful of change and what it would mean for them and others like us. One of the women interviewed told me that it was our job – the ones who had survived – to lead the way for other generations of women to come "the stronger must lead the way…"

For that hopeful comment I am thankful because it spoke volumes about how valuable these people's voices are and the possibilities within user-led perspectives in mental health. In that last comment I have found courage to keep fighting for women's rights in healthcare.

Bibliography

A vision for change: *Report of the expert group on mental health policy (2006)*. The Stationery Office: Dublin.

Alldred, P., Crowley, H., Rupal, R. (Eds). (Summer 2001) *Women and Mental Health*. Feminist Review, No. 68: 1-5. Routledge, Taylor & Francis Group: UK. http://www.tandf.co.uk/journals

Annandale, E. (2009) *Women's Health and Social Change.* Routledge Taylor & Francis Group: London & New York.

Baptista, I. Women and Homelessness: *Reflections on Homelessness and Research In Europe.* www.ebscohost.com 06/03/2013

Barnes, M., Bowl, R (2001) *Taking Over the Asylum: Empowerment and Mental Health*. Palgrave.

Barry, U. (Ed) (2008) *Where are we now? New feminist perspectives on women in contemporary Ireland.* Tasc: New Island.

Bledsoe, C. (2001) '*Unique Eyes and Different Windows of Opportunity: The Consumer Provider Perspective'.* In: Brown, C. (Ed). *Recovery and Wellness: Models of Hope and Empowerment for people with Mental Illness.* Routledge: USA

Bloom, L. (1998) *Under the sign of hope: Feminist methodology and narrative interpretation.* State University of New York Press: USA.

Bolton, G. (2005) *Reflective Practice: Writing and Professional Development, 2nd Edition.* London: Sage Publications.

Bowpitt, G., Dwyer, P., Sundin, E., Weinstein, M. (2010) *Comparing men's and women's experiences of Multiple exclusion homelessness.* In: Social Policy & Society 10 (4), 537-546: Cambridge University Press 2011.

Breggin, P. (1991) *Toxic Psychiatry*. St. Martin's Press: New York.

Buchanan, I. (2010) Oxford Dictionary of Critical Theory, First Edition. Oxford University Press Inc., New York.

Busfield, J. (1996) *Men, Women and Madness : Understanding Gender & Mental Disorder*. MacMillan Press Ltd: London.

Byrne, A., Lentin, R. (Eds). (2000) *(Re)searching Women: Feminist Research Methodologies in the Social Sciences in Ireland.* Institute of Public Administration: Dublin.

Byrne, M., Onyett, S. (2010) *Teamwork within Mental Health Services in Ireland: A resource paper.* Mental Health Commission: Dublin.

Chamberlain, J. (2005) *User/consumer involvement in mental health service delivery*. Epidemiologica e Psichiatria Sociale: Vol:14 (1): 10-14. (Accessed via Google Scholar 03/05/2012).

Corry, M., Tubridy, A. (2001) *Going Mad? Understanding Mental Illness*. New Leaf/Gill & MacMillan Ltd: Dublin.

Corry, M., Tubridy, A. (2005) *Depression: An Emotion not a Disease*. Mercier Press: Cork.

Crowe, K., Taylor, K. *The Recovery Approach: The Desired Service User Empowerment Process.* Irish Advocacy Network: Ireland. *In:* Sapouna, L., Hermann, P. (2006) *Knowledge in Mental Health.* Nova Science Publishers.

Cullen, P. (Health Correspondent). "*Mental Health Stigma fuelled by lack of understanding, research shows".* Irish times, Tues, Sept.11th 2012. Accessed: 11/09/2012.http://www.irishtimes.com/newspaper/ireland/2012/0911/1224323844387_pf.html

Deegan, Patricia, E. (2001) '*Recovery as a Self-Directed Process of Healing and Transformation*'. In: Brown, C. (Ed). *Recovery and Wellness: Models of Hope and Empowerment for people with Mental Illness.* Routledge: USA.

Doyle, Elaine. (2011) *Is A House Enough? Service Users perspectives on the reasons for repeat admissions to a female homeless service (Edel house).* School of Applied Social Studies, community academic research links/University College Cork. Available from http://www.ucc.ie/scishop/completed

Forchuk, C., Nelson, G., Brent Hall, G. (2006) "It's *important to be proud of the place you live in": Housing problems and preferences of psychiatric survivors*. Perspectives in psychiatric care, Vol.42 (1): 42-52. Source: Online Database: EBSCOhost: http://O-web.ebscohost.com.library.ucc.ie/ehost/delivery?=sidd4d63a97-165b-468a-95 06/03/2013

Foucault, M. (1971) *Madness & Civilization: A History of Insanity in the Age of Reason.* Tavistock: London.

Freedman, E. (2007) *The Essential Feminist reader*. Modern Library: United States.

Goffman, E (1991) *Asylums: Essays on the social situation of mental patients and other inmates*. Penguin: England.

Good Shepherd Services & Cork Simon Community. (October 2011) *Women's Health and Homelessness in Cork: A joint snapshot study of the Health and Related Needs of Women who are Homeless in Cork.*

Good Shepherd Services (2011) Annual Report. www.goodshepherdservices.ie

Gray, P. (2006) *The madness of our lives: experiences of mental breakdown and recovery.* Blackwell publishing Ltd: Oxford.

Hegadoren, K.M. *et al*, (2006) *Posttraumatic stress disorder part III*.
Hesse-Biber, S., Leavy, P. (2007) *Feminist Research Practice: A Primer*. Sage Publications: USA.

Higgins, A. (2008) *A Recovery Approach within the Irish Mental Health Services: A Framework for Development.* Mental Health Commission: Dublin.

Hough, Jennifer (2010) *Psychiatrist attacks gap in mental health services*. Irish Examiner: Friday, November 12, 2010. http://examiner.ie/ireland/psychiatrist-attacks-gap-in-mental-health-services-136262.html Sourced: 01/07/2011, 22.56.

Jill, K. Jesson, Lydia Matheson, Fiona M. Lacey., 2011. Doing *Your Literature Review: Traditional and Systematic techniques*. Sage Publications Ltd, London.

Jones, K. (1993) *Asylums and After: A revised History of the Mental Health Services: From the Early 18th Century to the 1990's*. Athlone Press Ltd: London.

Keane, M. (2012) *Findings from a Study of Homeless Women in Ireland.* Alcohol and Drugs News Letter: Issue 42 : 10-12. http://www.drugs andalcohol.ie/17688 Accessed 12/02/2013 17:54.

Kennedy, S (1985) *But Where can I go? Homeless Women in Ireland.* Arlen House: Dublin.

Letters: 'Cut *Price Therapy and the trauma underlying mental ill health*'. The guardian: 7th November 2012.

Mayock, P. & Sheridan, S. (2012) *Women's 'Journeys' to Homelessness: Key Findings from a Biographical Study of Homeless Women in Ireland* Dublin: School of Social Work and Social Policy and Children's Research Centre, Trinity College Dublin.

McDaid, Shari. (April 3013) *Recovery…what you should expect from a good quality mental health service.* Published by Mental Health Reform: Dublin.

McGee, H., Garavan, Rebecca. *(et al). (* 2002) *The SAVI Report: Sexual abuse and violence in Ireland*. Royal College of Surgeons in Ireland: Liffey Press: Dublin.

Mental Health Reform (2012). *Mental Health in Ireland*: Dublin.

Morris, P. *et al. Preparing for patient-centred practice: Developing the patient voice in health professional learning: 104-119.* In: Bradbury, H., Frost, N. *et al.* (2010) *Beyond Reflective Practice: New Approaches to Professional Lifelong Learning.*

Morrow, M., Chappell, M. (1999) *Hearing Women's Voices: Mental Healthcare for Women.* British Colombia centre of excellence for women's health: Vancouver.

National Women's Council of Ireland (2006b) Women's Health in Ireland: Meeting International standards. Dublin.

National Women's Council of Ireland (2010) *Submission to Budget 2011.* NWCI: Dublin.

National Women's Council of Ireland (March 2006a) Response to Mental Health Commission Discussion Paper: 'A Vision for A Recovery Model In Irish Mental Health Services'. NWCI, Dublin. Sourced 28/06/2011, www.nwci.ie : Publications 2006.

Norris, M., Kearns, N. (2000) "*The Changing Structure of the Homeless Population in Cork City: Implications for Theories of Homelessness and Service Provision*". Irish Journal of

Applied Social Studies*:* Vol.2 (2): Article 4. http://arrow.dit.ie/ijass/vol2/iss2/4 *Sourced: 06/03/2013.*

Phillips, L. (2006) *Mental Illness and the Body: Beyond Diagnosis*. Routledge: London & New York.

Pilgrim, D. (2005) *Key concepts in mental health.* Sage publications: London.

Pilgrim, D. (2009) *Key Concepts in Mental Health second edition.* Sage Publications Ltd: London.

Pilgrim, D., Rogers, A. (1999) *A sociology of Mental Illness.* Open University Press: Buckingham.

Ramon, S. *Service Users as Research Partners. In:* Sapouna, L., Hermann, P. (2006: 101-115) *Knowledge in Mental Health.* Nova Science Publishers.

Rapley, M., Moncrieff, J., Dillon, J. (Eds).(2011) *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Palgrave Macmillan: Great Britain.

Roulston, K. (2010) *Reflective Interviewing: A guide to Theory and Practice*. London: Sage Publications.

Ryan, P., Ramon, S., Greacen, T. (Eds). (2012) *Empowerment, lifelong learning and recovery in mental health: towards a new paradigm.* Palgrave Macmillan: U.K.

Schowalter, E. (1987) *The Female Malady*: Women, Madness and English Culture 1830-1980.Virago: Great Britain.

Shorter, E. (1997) *A History of Psychiatry: from the era of the asylum to the age of Prozac.* John Wiley & Son Ltd: New York.

Stoppard, J., McMullen, L. (2000) *Understanding Depression: Feminist Social Constructionist Approaches.* Routledge: London & New York.

Stoppard, J., McMullen, L. (2003) *Situating Sadness: Women and Depression in Social Context.* New York University Press: New York.

Szasz, T.S. (1961) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. Dell: New York.

The Way Home: *A strategy to address adult homelessness in Ireland 2008-2013*. Department of Environment, Local Heritage & Government: Ireland.

Tubridy, A. (2007) *When Panic Attacks: 2nd edition.* NewLeaf/ Gill & MacMillan Ltd: Dublin.

UN Commission on the status of women, fifty-seventh session: 4th -15th March 2013.

Ussher, J. (1991) *Women's Madness: Misogyny or Mental Illness?* Harvester Wheatsheaf: United Kingdom.

Ussher, J. (2011) *The Madness of Women: Myth and Experience.* Routledge: United Kingdom.

Williams, P. (2012) *Rethinking Madness: Towards a Paradigm Shift in Our Understanding and Treatment of Psychosis.* Sky's Edge Publishing: San Francisco. www.skysedgepublishing.com

Women's Health Council (2005) *Women's Mental Health: Promoting a gendered approach to policy and service provision*. Department of Health & Children: Dublin. http://dohc.ie/publications/women_mental_health

World Health Organisation (2003) *Investing in Mental Health. DOI: http://www.who.int/mental_health/publications/investing_mental_health/en/*

www.mentalhealthireland.ie

www.mhcirl.ie (Mental Health Commission)

www.mhrc.ie (Mental Health Reform)

www.nwci.ie (National Women's Council of Ireland)

Appendix 1
List of Support Services

Appendix 2
The Interview Guidelines

Semi- Structured Interview Guidelines for Good Shepherd Aftercare Services

(Guidelines adapted from Roulston, 2010 'Reflective Interviewing: A guide to Theory and Practice').

1. *Introductory Phase:*

Introduce myself as a women's studies student and a service user who is researching women's experiences of mental health care in Cork.

Explain that one of the purposes of the interview is to find out about their experiences of the services they have used in order to compile a list/booklet of information that would be helpful as a directory. It would be good to have their input into what is good or not so good about the services and how they can be improved. I would also like to find out about our particular needs as women and their (the interviewees) opinions on how women (as service users) as treated in mental health services.

Indicate that the interview is not formal – please speak freely and add anything that may be helpful.

Give a timeframe – interview will take about 45 minutes but please stop at any time if uncomfortable or prefer to take a break. Only speak about what you feel comfortable sharing.

Consent: Inform the interviewees that the conversation is being recorded and will be used as part of the research. Provide reassurance regarding privacy and anonymity. Ask for permission to use direct quotes from the transcript explaining that the research is being done from service-users perspective so it is their words and not my own that will be needed.

Sign Consent form.

Invite the person to talk about their experiences – asking them how they have come to aftercare services seeks to give them a starting point in telling their story. It may ease them into the conversation and will be a way of eliciting information about which services they have used in the past/leading to present.

2. *Information seeking: Answering The Research Questions*

As the interviewee narrates her story the researcher will be able to pick up on the details of which services have been used – if not use probes such as '*which service'*. From this point further information can be teased out. Using the following as a guideline:

i. What other supports have you used? Include telephone helplines/drop-in groups & counselling services
ii. Referral procedure: How did you find out about it? Were you referred by someone or did you arrange it yourself?
iii. Was there enough information available about the service (a leaflet/website) Did you know anything about it before you went? Were you able to find out about it?
iv. What about the location? Was it easy to get there?
v. Were there waiting lists? If so, what support did you have while you were waiting?
vi. Which service did you think was the most helpful?
vii. What was helpful about it? Can you tell me how (if) it improved your life i.e helped you cope with mental health problems/medication/family life/loneliness.
viii. What did you think was the least helpful thing about support services?
ix. How would you improve them?
x. What would you like to see as a support service? What would it be like/where would it be?

3. *Exploring service-user Involvement*
   i. Were there different options for support offered to you? (When referral was being made) Did you feel that you had a choice?
   ii. Were you ever asked or encouraged to give feedback about the services – this could be feedback forms, conversations with nurses, doctors or social workers/keyworkers.
   iii. Do you think that women who use the services get to have a say in how the services are run? Has anyone asked you before now?
   iv. If you spoke about these things, do you feel that you were listened to? That you were respected? Were staff and other service-user respectful of you?
   v. Do you feel that professionals/staff/doctors are approachable about talking about these things (giving feedback/having a say).
   vi. Would you like to be involved in or have the opportunity to say how services are being run?

4. Researching Women's Mental health
   i. What is your opinion on the research? Do you think that women have specific needs when it comes to mental health support? Can you give me examples?
   ii. Do you think it would improve the services if women's needs were considered?
   iii. How did you find doing this interview?
   iv. How do you feel about it being used as part of research?

Ending with thanks for their contribution and their time.
The manager will be there for support if they need it after the interview.
Inform them that the finished research will be given to the Aftercare Services Manager & they are welcome to read it and give feedback about it.