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

Response to: Equality Action Plan
Disability Action Plan
(2018-2023)
Consultation Document

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

1. Introduction

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

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

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

1.3 The Consortium is the established link and strategic partner between government and statutory agencies and women in disadvantaged and rural areas, including all groups, centres and organisations delivering essential frontline services, advice and support. The Consortium ensures that there is a continuous two way flow of information between government and the sector. It also ensures that organisations/centres and groups are made aware of consultations, government planning and policy implementation. In turn, the

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

Consortium ascertains the views, needs and aspirations of women in disadvantaged and rural areas and takes these views forward to influence policy development and future government planning, which ultimately results in the empowerment of local women in disadvantaged and rurally isolated communities.

1.4 This response is informed by women's perspectives articulated in Consortium engagement events, including ethnic minority engagement, reflecting the views of Consortium regional membership bases.

2. General comments

The Women's Regional Consortium appreciates the opportunity to respond to the Department of Health's 'Equality action plan disability action plan (2018-2023) consultation document'.

The Consortium works to advance the interests and wellbeing of disadvantaged, marginalised women in some of the most deprived areas of Northern Ireland. These cohorts include women in - and at heightened risk of - different kinds of poverty, including persistent in-work and intergenerational variants. Poverty can be a significant risk factor in ill health.[2] And, as research affirms, the relationship between poverty, health inequality and gender is such that poor women may be at particular risk of different kinds of constrained health outcomes in the life course:

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

Given the association between disability, gender, poverty and health inequality, poor disabled women may be at additional risk.

From this perspective, we welcome the consultation as affirmation of departmental intent to renew its focus on addressing health inequality affecting

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

those with and without a disability, including the particular kinds of inequality that can affect those in the most deprived areas of the jurisdiction. *Yet, in a context of sustained austerity, characterised by 'systemic and long-term' under-resourcing and under-provision across different kinds of health need,*[4] associated with 'substantial' treatment delays,[5] *we remain profoundly concerned about government capacity to deliver on this intent in substantive ways.*

As is well established, this austerity model has aggravated poverty and vulnerability while disproportionately affecting women, making 'many women poorer and less financially autonomous'.[6] And, because, as noted, poverty can be a significant risk factor in ill health,[7] this exacerbation of poverty has, in turn, been associated with (i) heightened risk to poor women's wellbeing and (ii) stimulated health service demand.[8] The controversy at the heart of this policymaking nexus is thus this: ongoing austerity has the potential to significantly augment the health needs of the most vulnerable while severely constraining provider potential to properly meet those needs.

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

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

dissatisfaction with service levels and quality while directed, in general, at the wider health sector focussed, in particular, on hospital delivery and primary care provision at the level of general practitioner and community outreach.

Obviously, in addition to proper resourcing, realisation of any such policymaking would fundamentally rely on the availability of a robust gender disaggregated data evidence base that accurately captured the implicated intersectionality in this debate, for example, interaction between gender, health and ethnic minority status. Lamentably, however, such an evidence base is conspicuously absent given prevailing gaps in government information gathering and data collation (both quantitative and qualitative).

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

3. Specific comments

3.1 Disadvantaged women and healthcare: mental health debacle

In critically reviewing the departmental action plans, participants prioritised the question of healthcare policy in respect of disadvantaged women in both rural and non-rural regions of the jurisdiction. This exploration was dominated by mental health considerations, wherein discussants made the case for policymaking to address the wider relationship between austerity, poverty, gender, under-resourcing of healthcare, the legacy of the conflict and women's constrained wellbeing.

As noted, cohorts disproportionately impacted by ongoing austerity include the most vulnerable and the poor,[9] and its cumulative adverse impact on everyday lives has thus been partially characterised in terms of exacerbated vulnerability and poverty.[10] Because poverty can be a significant factor in mental ill health,[11]

[9] See, for example, C. Beatty and S. Fothergill, 'Hitting the poorest places hardest: the local and regional impact of welfare reform', Sheffield Hallam University: Sheffield, 2013. See also, J. Ginn, 'Austerity and inequality: exploring the impact of cuts in the UK by gender and age', Research on Ageing and Social Policy, 1(1), 28-53. Further see H. Aldridge and T. McInnes, 'Multiple cuts for the poorest families', Oxfam: London, 2014.
[10] Ibid. See, also, M. Aylott et al. 'An insight into the impact of the cuts on some of the most vulnerable in Camden', Young Foundation: London, 2012.
[11] See, Murali and Oyebode, op. cit.

this exacerbation of poverty has, in turn, been associated with diminished mental wellbeing.[12] Within this context, it has been established that this austerity model, precisely by disproportionately impacting women adversely and therein aggravating the relationship between gender and poverty, has had a 'devastating' impact on women's health,[13] including their mental wellbeing.[14] Research thus suggests some kind of correlation between austerity-driven fiscal restraint, poverty, gender and mental health.[15]

The adverse impact of ongoing austerity on the funding of mental health provision in the Northern Ireland case has also been noted. Research points to 'systemic and long-term' austerity-driven under-funding,[16] with attendant problematic provision in areas such as psychological therapies, early intervention and suicide prevention.[17]

Of course, women's experience of mental ill health in disadvantaged and rural areas of the jurisdiction can also correlate strongly to the legacy of the conflict. Disadvantaged individuals in the jurisdiction are in general 'much more likely' to cite an impact of the conflict on their everyday lives,[18] while women are more likely than men to report signs of mental ill health.[19] The 'burden' of conflict-associated anxiety and depression tends to fall disproportionately on women, and disadvantaged women are in general 'at a greater risk of depression compared to less disadvantaged women'.[20] The interaction between these

[12] Supra note 8 pertains.
[13] L. James and J. Patiniotis, 'Women at the cutting edge: why public sector spending cuts in Liverpool are a gender equality issue', Liverpool John Moores University: Liverpool, 2013, p.12.
[14] On this, see LMHC, op. cit.
[15] Ibid.
[16] Wilson et al., op. cit., p.2, p.v.
[17] J. Thompson, 'Mental health and illness in Northern Ireland (1): overview – related strategy and reports'. [Online]. Available at:http://www.assemblyresearchmatters.org/2017/03/08/mental-health-illness-northern-ireland-1-overview-related-strategy-reports/
[18] C. C. Kelleher, 'Mental health and "the Troubles" in Northern Ireland: implications of civil unrest for health and wellbeing', Journal of Epidemiology and Community Health 2003; 57:474-475, p.474. See also, C. C. Kelleher, D. O'Reilly and M. Stevenson, 'Mental health in Northern Ireland: have 'the Troubles' made it worse?' Journal of Epidemiology and Community Health, 2003; 57: 488-492.
[19] Mental Health Foundation, 'Mental health in Northern Ireland: fundamental facts 2016', MHF: London, 2016.
[20] M. Teychenne, K. Ball and J. Salmon, 'Educational inequalities in women's depressive symptoms: the mediating role of perceived neighbourhood characteristics', International Journal of Environmental Research and Public Health, Dec: 9(12): 4241-53, 2012.

factors suggests a distinct correlation between disadvantage, gender, conflict and mental ill health.[21] By imposing 'substantial' treatment delays for conflict-related disorders,[22] the austery-driven underfunding at hand potentially risks aggravating this correlation, further threatening the mental wellbeing of disadvantaged women while heightening the risk of aggravated health inequality.

This picture of constrained wellbeing is further complicated by consideration of rural-specific contextual factors. This includes the cumulative adverse impact on everyday lives of the enduring legacy of infrastructural underinvestment in rural, and subsequent rural/urban socio-economic indicator differentials,[23] which research associates with aggravated isolation and disconnectedness.[24] Isolation remains a key risk factor in mental ill health.[25]

Participants noted the profound impact on service users and carers' wellbeing of this status quo. This predicament was presented as compounded by the withdrawal and threat of withdrawal of vital frontline provision for women at the level of the community, including outreach provision for the most vulnerable and at-risk.

Recent departmentally commissioned research lends insight into what is at stake in this debate, illustrating the at-risk cumulative contribution of women centre delivery to the government's own prevailing anti-poverty agenda.[26] The women's centre delivery model seeks to address the complex nature of women's vulnerability through integrated provision. And, its anti-poverty impact

[21] See, for example, Commission for Victims and Survivors, 'Towards a better future: the trans-generational impact of the Troubles on mental health', Commission for Victims and Survivors: Belfast, 2015.
[22] Wilson et al., p.27.
[23] For example, as the executive's own research puts it in respect of public sector funding differentials to the wider women's sector: 'compared with levels of government funding to women's groups in urban areas, there was a relatively low level of government funding to rural women's groups'. DSD/OFMDFM, 'Review of government funding for women's groups and organisations', DSD/OFMDFM: Belfast, 2012, p.13.
[24] See, for example, M. Allen, 'Rural isolation, poverty and rural community/farmer wellbeing - scoping paper', Research and Information Service Briefing Paper, NIA: Belfast, 2014.
[25] Thompson, op. cit.
[26] See, Morrow Gilchrist Associates, 'Evaluation of regional support arrangements for the voluntary and community sector', Morrow Gilchrist Associates: Belfast, 2015.

is characterised in terms of remedial outcomes across different kinds of disadvantage, including intergenerational variants and that experienced by ethnic minorities, as well as different kinds of poverty, including in-work, gender and child poverty.[27] More precisely, that differentiated impact is presented as entailing the delivery of a plethora of positive developmental outcomes at the level of the individual, the wider family, the community and society at large, from enhanced individual wellbeing, agency and life chances through to improved community cohesion and economic capability.[28]

Participants made the case not only for retention of such provision, but also expansion, complemented by improved signposting to same across the health sector at large. More generally, the case was also made for early intervention - at pre-school and school age - to address key factors underlying all health inequalities between the most and least deprived areas.

The question of enhanced intervention - *or lack thereof* - on this front has clear rights implications: most obviously, perhaps, the United Nations Committee on the Elimination of Discrimination Against Women has urged government to mitigate the impact of ongoing austerity on women and services delivered to women. Self-evidently, the prospect of meaningful analysis of any such mitigation across the austerity project at large would intrinsically rely on the inclusion of a robust gender perspective underpinned by a robust, reliable relevant disaggregated evidence base.

Recommendation

In pursuit of improved mental health outcomes for disadvantaged women, government should attend to the cumulative mental health impact of ongoing austerity and the legacy of the conflict, while also ring-fencing mental health from any further fiscal cuts under extended austerity. In addition, the role of community-based provision in addressing this disadvantage and its implications for cohort wellbeing should be properly recognised and sustainably supported.

[27] Ibid.
[28] Ibid.

3.2 Recognition of black and ethnic minority need

Participant discussion underscored the requirement for healthcare policy prioritisation in Northern Ireland to deliver proper recognition and accommodation of black and ethnic minority (especially migrant and refugee) cohort need, to explicitly include proper identification of, and effective action on, health inequality. This sub-section considers implicated issues.

The Consortium remains concerned about the apparent lack of policy capacity in the jurisdiction to properly identify and address the relationship between poverty, ethnic minority status and health need/inequality. This concern is informed by consideration of the worrying dearth of reliable disaggregated data on the everyday experiences of ethnic minorities in the region, in terms of outcomes in health and beyond (inter alia, education, housing and benefit receipt),[29] as well as racism and racial inequalities.[30]

Research suggests that disadvantage and 'severe' disadvantage associated with the experience of racism and racial inequalities can fundamentally impact individuals' life choices/chances and wellbeing, including their mental health.[31] But the research deficit under review frustrates attempts to accurately gauge the ethnic minority experience of poverty: in the absence of sufficiently detailed disaggregated ethnic data, 'the situation of disadvantaged ethnic minorities cannot be ascertained but only guestimated'.[32]

The substantive point here is this: because evidence-informed policymaking can better enable the development of strategies and services that explicitly recognise and take account of the diverse experiences and needs of different

[29] A. Wallace, R. McAreavey and K. Atkin, 'Poverty and ethnicity in Northern Ireland: an evidence review', Joseph Rowntree Foundation: London, 2013.
[30] Wallace, McAreavey and Atkin, op. cit.
[31] Ibid., p.4. See, for example, 'Does racial discrimination cause mental illness?' A. Chakraborty and K. McKenzie, *The British Journal of Psychiatry* (2002), 180: 475-77. That said, this area of the literature remains underexplored.
[32] Quoted in ECNI, 'Racial equality', ECNI, 'Racial equality - policy priorities and recommendations (key point briefing)', ECNI: Belfast: 2014, p.41. The idea is that '*robust research* that measures the extent of poverty among people from minority ethnic groups and how their experiences compare with other groups, within Northern Ireland or with the rest of the UK or the Republic of Ireland, *is largely absent'*; Wallace, McAreavey and Atkin, op. cit, p.24

kinds of groups, such deficits can frustrate the proper assessment and monitoring of inequalities (in health and beyond) and any associated remedial actions.[33] In short, if healthcare need cannot be properly identified/quantified, then it cannot be meaningfully addressed, and the result can be a lack of proper recognition and accommodation of ethnic minority need.

Against this backdrop, participants anecdotally presented a worrying picture of ethnic minority engagement with the wider healthcare sector. This ranged from accounts of service denial (in the absence of requisite identity documentation among migrant/refugee cohorts) through to lack of cultural awareness, linguistic non-accommodation and, worst still, racist encounter (attitudinally and behaviourally).

A general appeal followed for substantive remedial action to address this dilemma, taking better account of multiple identities in policy planning and implementation, to include improved staff training across all implicated public bodies.

Recommendation

Government should undertake measures to ensure proper recognition and accommodation of black and ethnic minority needs and interests in healthcare service design and delivery. Due regard should be given therein to any significant prevailing disaggregated data gaps such as might threaten to undermine efficacy on this front.

3.3 Health inequality and disability: rights perspective

The Consortium would urge government to take more steps to encourage and facilitate participation by disabled people in public life beyond those set out in the documentation, steps which might ultimately allow it to better address the relationship between disability, lack of participation and health inequality.

The relationship at hand is well established in the literature. Research affirms that ‘becoming disabled’ entails a significant risk factor in vulnerability to social

[33] Ibid.

exclusion and poverty given its impact on individuals' participation in employment and civil society: 'disabled people are disproportionately likely to be out of work, on low incomes and unable to participate in social activities'.[34] Prejudicial attitudes and behaviour in public life from employers and others can compound matters, further constraining participation in different ways. Infrastructural inadequacies, such as in transport, can further complicate this picture of exclusion and constrained participation, undermining the capacity of disabled cohorts to live independently. Longstanding underinvestment in rural infrastructure correlated to rural isolation – as noted, a risk factor in mental ill health - can mean rural disabled cohorts in the jurisdiction may be at additional risk of exclusion, restricted participation in public life and health inequality.[35] Discussants anecdotally evidenced these associations, appealing for more meaningful implementation of existing legislation and strategy on rural proofing and disability.

Cultivating a substantive human rights perspective on this debate would allow government to properly capture and take account of the wider social justice issues at stake in this debate. The importance of such a manoeuvre was recently underscored by research that examined the implementation of United Nations Convention on the Rights of People with Disabilities requirements in public policy and programme delivery in the Northern Ireland case.[36] Focussing specifically on how policy and programme outputs have failed to meet these requirements, the project identified 'substantive shortfalls' in respect of disabled people 'living independently and being included in the community'.[37] To a significant degree, explanation for these shortfalls was attributed to 'problems with a lack of joint working' across departments.[38] Commentators have also noted the social justice imperative to mitigate the adverse impact of austerity on services for women with a disability.[39]

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[34] T. Burchardt, 'Being and becoming: social exclusion and the onset of disability', JRF: London, 2003, p.5.
[35] B. Byrne et. al., 'UNCRPD: shortfalls in public policy and programme delivery in Northern Ireland relative to the articles of the UNCRPD, final report', ECNI: Belfast, p.133.
[36] Ibid.
[37] Ibid., 108.
[38] Ibid., pp.107-8.
[39] Ibid.

However, the prospect of cultivating a robust rights perspective on this debate is frustrated by a dearth of reliable disaggregated data on this front: '[there are] significant gaps in knowledge with respect to the rights of women with disabilities in Northern Ireland … more information and data is also needed on [their] circumstances'.[40]

Participants called for strategic remedial action from government to address this dilemma.

Recommendation

Government should seek to address more effectively the relationship between poverty, health inequalities and disability, cultivating a rights perspective on this debate such as would allow it to properly identify and take account of the wider social justice issues at stake. Due regard should be given therein to any significant disaggregated data gaps such as might threaten to undermine that undertaking.

4. Conclusion

This paper has set out a social justice case for policymakers to properly capture and address the complexity of the relationship between austerity, gender, poverty, disability and health inequality in the Northern Ireland case. For obvious reasons, this advocated policy manoeuvre has been defined in terms of properly resourced and properly informed intervention. Of course, the notion of proper resourcing remains inconsistent with the status quo of austerity modelling. This raises the question of challenge to that modelling at the level of the political.

The United Kingdom's impending exit from the European Union (Brexit) further complicates this debate. Research suggests Brexit could significantly

[40] Ibid.

aggravate pre-existing inequality and vulnerability, disproportionately impacting women.[41] A robust gender perspective on the wider debate remains paramount.

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

Summary of Participant Reported Concerns

- Chronic underfunding and underprovision across health sector at large, mental health acutely impacted
- Seismic cuts to community-based provision, in general, and community-based mental health provision, in particular, including psychiatric outreach and clinic delivery
- Endemic service withdrawal:
    - rural underfunding and underprovision compounded by infrastructural barriers to service access, notably transport shortfalls;
    - particular emphasis placed on Derry, Strabane, Lisburn and greater Belfast (specific examples cited included withdrawal of treatment for lipoedema and lymphedema in Strabane and maternity services in Omagh)
- Over-prescribing of medication in the absence of alternative treatment methodologies/pathways, such as counselling and outreach
- Lack of proper recognition and accommodation of ethnic minority health need correlated to lack of appropriate staff training, including lack of equality awareness training
- Racist staff attitudes and behaviour
- Lack of empathy and understanding among providers in respect of mental health
- Sense of abandonment among those with mental illness seeking support services and treatment
- Sector-wide service user neglect: significant failings in continuity of care and care planning
- Inadequate social care, including dementia provision
- Treatment delays and postponement (waiting lists and waiting times across different interfaces, including hospital and general practitioner services, particularly out of hour services)
- 'Not fit-for-purpose' social service delivery
- Reluctance among those with mental health issues to approach general practitioners for treatment through fear of implications should social services become involved, most notably, fear of removal of children from family home
- Lack of integrated care and service provision
- Under-provision and dysfunctionality in social care
- Requirement for properly integrated health and social care
- Ambulance service inadequacies
- Improved early intervention and support required
- Shortfalls in health education programmes
- Dysfunctionality in primary care
- Neglect of community hospital need