



British Columbia
Centre of Excellence
for Women's Health

Vancouver, BC
CANADA

Violence and Trauma in the Lives of Women with Serious Mental Illness

Current Practices in Service
Provision in British Columbia

By **Marina Morrow**

Report available
in alternate formats



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Provision in British Columbia

By Marina Morrow





**British Columbia
Centre of Excellence
for Women's Health**

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Women's Health Reports

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ISSN 1481-7268
ISBN 1-894356-24-1

Executive Editor Lorraine Greaves

Senior Editor Leslie Timmins

Copy Editor Robyn Fadden

**Graphic Design
& Illustration** Michelle Sotto

**Canadian Cataloguing
in Publication Data**

Morrow, Marina Helen, 1963-

Violence and trauma in the lives of women
with serious mental illness: current practices
in service provision in British Columbia

(Women's health reports, 1481-7268)

Includes bibliographical references.

1. Women--Mental health services--British
Columbia. 2. Mentally ill women--Violence
against--British Columbia. I. BC Centre of
Excellence for Women's Health. II. Title. III.
Series: Women's health reports (Vancouver, B.C.)

RC451.4.W6M658 2002
362.2'082'09711
C2002-911058-0

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Acknowledgments

This project was conducted out of the British Columbia Centre of Excellence for Women's Health with funding from the British Columbia Ministry of Health Services (formerly the Ministry of Health). This research would not have been possible without the support and guidance of the Violence and Mental Health Advisory Committee, whose membership included: Liz Choquette, Chris Downing, Judith Hayes, Marilyn Irwin, Paula Marlatt, Katherine McIndoe, Victoria Schuckel, JoAnne Svensson, Helen Turbett, and Kathleen Whipp.

Special thanks to Monika Chappell for her work on helping to organize and analyze the data, Janet Walker for her research assistance, and Deirdre Evans and Jill Stainsby for their helpful comments on earlier drafts of this report. Appreciation goes to Victoria Schuckel and Lorraine Greaves, who provided thoughtful and detailed feedback on the report.

Thanks also to our editor Janet Money, our copy editor Robyn Fadden and to graphic designer Michelle Sotto.

Finally, we appreciate the many mental health professionals and community-based practitioners who took the time to attend focus groups, be interviewed or fill out a survey.

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**Women’s past
experiences of violence
and their increased
vulnerability to abuse
once they become ill
are not routinely taken
into account in treatment
and support.**

Executive Summary

Violence and trauma are serious health concerns for women. Researchers and practitioners in mental health are becoming more and more aware of the impact of violence on the lives of women with chronic and persistent mental health problems. The development of appropriate support and treatment responses for this population has been hindered, however, by disagreements about the role of violence and trauma in the etiology of mental illness, and debates about how mental health practitioners should address women’s experiences of violence.

This paper documents the practice in five different mental health care settings in two British Columbia health regions (Vancouver/Richmond Health Board and the Capital Health Region¹) with respect to the provision of services to women with chronic and persistent mental health problems who are survivors of violence. Focus groups and interviews were used for the five mental health care settings. Additionally, survey tools were used to gather information about programming across all health regions in British Columbia.

Despite a commitment in the British Columbia Mental Health Plan (1998) to a “bio-psycho-social” framework for addressing mental health problems, this research shows that current practice is still primarily guided by a bio-medical paradigm. In particular, mental health programming and planning at all levels do not systematically attend to the social determinants of mental health. As a result, women’s past experiences of violence and their increased vulnerability to abuse once they become ill are not routinely taken into account in treatment and support. Although some individual practitioners recognize the impact of violence and trauma on the lives of their clients, their responses are hindered by lack of training and by the mandate and resource restrictions of their organizations. Practitioners noted that women with diagnoses of borderline personality disorder, women with co-existing substance use and mental illness, women in prison, women with developmental disabilities, and Aboriginal, immigrant and refugee populations are particularly in need of specialized services.

In this report it is recommended that mental health policy makers and planners provide leadership in the development of training and practice guidelines for working with women who are trauma and violence survivors. The use of an integrative model (i.e., one that draws on both bio-medical and social justice understandings of violence and trauma) is supported as the best framework from which to design programs for women. Further, it is recommended that collaborations and cross-training between the mental health sector and organizations addressing violence against women in the community take place. Different but at times complementary kinds of experience and expertise have developed in both locations, which can be usefully drawn on in the development of new programming.

This research highlights several key initiatives already underway in British Columbia that can be strengthened and expanded. It is argued that the system is ready to build its capacity to systematically address violence and trauma in the lives of women with chronic and persistent mental health problems.



In the general population, 29% of women ever married have been sexually or physically assaulted by their partner; in British Columbia that percentage is even higher at 36%.

Introduction

Within the field of trauma studies the terms “violence,” “abuse” and “trauma” are used in a variety of (often overlapping) ways to refer to a broad spectrum of human experiences.² This project is specifically focused on service provision to women who have experienced various forms of intimate violence, that is, physical, sexual, emotional and verbal abuse as children or adults.

Increasingly, it has come to be recognized that many men in the mental health system are also survivors of child sexual and physical abuse (Fisher, 1998). Although the focus of this report is on women, it is recommended that further research be carried out to understand the particular needs of male survivors.

As outlined in this report, debates exist about the role of violence and trauma in the etiology of mental illness. These debates notwithstanding, mental health practitioners are converging in their recognition that many of their women clients come to them with prior or current experiences of violence. Mental health practitioners are therefore increasingly recognizing the need for assessment tools and treatment planning that are better able to take into account the impact of violence and trauma on mental health.

This report provides a review of current practices addressing women’s experiences of violence, as well as suggestions and examples of how to help policy makers and practitioners respond more effectively to women.

Increasingly, the prevalence of violence against women and the impact of violence and trauma on women’s physical and mental health have come to be recognized. Canadian statistics suggest that in the general population, 29% of women ever married have been sexually or physically assaulted by their partner; in British Columbia that percentage is even higher at 36% (Rogers, 1994; Johnson, 1996). Twenty-one percent of women are assaulted during pregnancy, and in 40% of these cases the abuse first began during pregnancy (Johnson, 1996). Although there is no recent national data on child sexual abuse, in 1984 the Badgely

Report found that approximately one in two females and one in three males have been victims of unwanted sexual acts. Four out of five of these incidents were committed when the person was a child or a youth (Badgely et al., 1984).

The prevalence of child sexual abuse appears to be even higher in the population of women psychiatric inpatients. One British Columbia study, which surveyed women at Riverview Psychiatric Hospital, found that 58% had been sexually abused as children (Fisher, 1998). When both physical and sexual abuse were taken into account, Firsten (1991) found that 83% of women in an inpatient setting had had these experiences. American studies which look at the prevalence of sexual abuse in the lives of women diagnosed with mental illness find similar rates (Beck & van der Kolk, 1987; Craine et al., 1988; Rose, Peabody & Stratigeas, 1991).³ Some researchers have found differences in the severity and duration of abuse for clinical versus non-clinical populations, with women in the former category reporting the experience of higher rates of violent abuse of longer duration (Herman, Russell & Trocki, 1986).

The physical health impact of violence on women has been well documented and violence has been

recognized as a health priority in British Columbia⁴ and in the Vancouver/Richmond Health Region.⁵ At the most extreme end, violence results in serious physical injury and death.⁶ A whole host of other physical health problems have been linked to experiences of abuse and trauma, including central nervous system damage (van der Kolk, 1988), sleep disorders (van der Kolk & Fisher, 1993), migraines (Wahlen, 1992), respiratory-related problems (Reilly, 1992), cardiovascular system problems (Reilly, 1997), endocrine problems (Jancin, 1991), gastrointestinal and genito-urinary problems (Walker, Katon, Harrop-Griffiths, Holm, Russon & Hickok, 1988), and reproductive (Jacobs, 1992) and sexual problems (Westerlund, 1992).

The reported mental health sequelae of physical and sexual abuse in childhood have been described as “diffuse, overlapping and confounded by other variables” (Rosenberg, Drake & Mueser, 1997: 262). Increasingly, however, researchers are attempting to understand the impact of early childhood trauma on mental health. Studies have linked early childhood trauma to depression, borderline personality disorder, multiple personality disorder and substance abuse (Nash, Hulsey, Sexton, Harralson & Lambert, 1993; O’Donohue & Greer, 1992). Child-

The risk and impact associated with violence are compounded if a woman is socially marginalized or living in poverty.

hood trauma has also been linked to post-traumatic stress disorder (Courtois, 1986; Eth & Pynoos, 1985; Goodwin, 1985). Debates exist, however, that challenge the application of certain diagnoses (e.g., personality disorders, post-traumatic stress disorder) to abuse survivors, arguing that this obscures the etiology of women's symptoms (Wasserman & Rosenfeld, 1992; Herman, 1992). These researchers point to a unique set of symptoms, such as feelings of powerlessness, dissociative symptoms and self-blame, that result from early and chronic sexual abuse.

The health care costs of violence against women in Canada have been estimated at \$1,539,650,387 annually (Day, 1995). Few studies have assessed the psychiatric health care costs of violence. However, a Canadian study by Ross and Dua (1993), which focused on the costs associated with the care of 15 female abuse survivors diagnosed with multiple personality disorder, found that the women spent an average of 98.7 months in the Canadian mental health care system before being properly diagnosed, at a lifetime cost of \$4,144,114.50. They estimate that a savings of \$84,899.44 per person could be achieved if earlier and accurate diagnosis were to occur.

Although all women are vulnerable to violence regardless of their race, ethnicity, culture, physical/mental ability, age, sexuality or economic status, the risk and impact associated with violence are compounded if a woman is socially marginalized or living in poverty (Gurr, Malloux & Kinnon, 1996). Women who have serious mental health problems are particularly at risk because of their illness and their social and living situations (Anderson & Chiochio, 1997). Violence, in this context, is both a feature of women's histories and a reality of their present-day lives. The particular stigmatization and discrimination that accompanies mental illness makes it especially difficult for this group of women to receive appropriate care and support. As Harris puts it:

"Once we have labeled a woman as suffering from a major mental illness, whether that label is an accurate assessment or not, we view her reports of sexual and physical abuse through the coloured lens of her diagnosis.... The stigma of her diagnosis is often sufficient to call her account into question." (1997: xii)

This discrimination has origins in the early practice of psychiatry and psychology, which has been dominated by what Reilly (1997) refers to as the "victim-blaming" model. This model led professionals to seek an

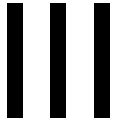
explanation for the perpetrator's crimes in the character of the victim. Feminist critiques of this approach led to a re-conceptualization of violence as a social and political problem for women (Herman, 1992; Rush, 1980; Armstrong, 1978; Armstrong, 1994).

In the current mental health system, an illness/bio-medical model prevails (Reilly, 1997) that generally ignores the role of violence and trauma in the etiology of mental illness. Within this paradigm, women are primarily assessed to determine their psychiatric diagnosis and their symptoms are then treated through the use of psychotropic medications.

On the one hand, illness/bio-medical models generally do not emphasize the social context of women's lives when assessing and treating women. On the other hand, models that focus on the social context of women's lives do not always adequately recognize the possible interconnections between chronic mental health problems and violence. In recognition of these inadequacies, a third, integrative model is emerging (Reilly, 1997). This model recognizes that violence and trauma may be significant features of the lives of women who have been diagnosed with serious mental illness. It further recognizes the particular vulnerability of this popula-

tion with respect to being re-traumatized through inappropriate treatment, being misdiagnosed, and being marginalized because of discrimination.

This report suggests that an integrative model is the most useful framework for designing programs for women with chronic and persistent mental health problems. We illustrate how the mental health system in British Columbia in two regions is currently addressing this problem and make the argument that there is a need for more responsive, women-centred services and supports for women. Indeed, a substantive body of theory and practice now exists to guide practitioners working with trauma and violence survivors.



As trauma studies gain credibility within the fields of psychology and psychiatry, violence against women is now beginning to be understood as having a serious impact on mental health.

The Relationship Between Violence and Mental Health

“Given the complex interrelationship between sexual abuse and diagnosed mental illness, how do we begin to discuss the impact of sexual abuse trauma on the lives of women who receive treatment within the mental health system for a diagnosed illness?” (Harris, 1997: xii)

Although prevalence studies now confirm that violence and trauma are higher in both mental health inpatient and outpatient populations (Fisher, 1998; Firsten, 1991; Muenzenmaier, Meyer, Struening & Ferber, 1993; Craine et al., 1988), debate still exists about the role of violence in the etiology of mental illness. This study did not seek to determine this role, but current practice must be contextualized by the debate surrounding this. Practice is, in part, linked to service providers’ understanding of violence against women and the role this understanding plays in the development and/or exacerbation of mental health problems. In our study, although not all practitioners shared the same understanding of the relationship between violence and mental illness, most believed that it was an issue that needed to be addressed in the mental health system. Participants in our study, however, may not be representative of practitioners in general – indeed, many spoke about their colleagues’ hesitancy to acknowledge and address child sexual abuse and violence against women.

The discrimination against people with mental illness combined with a social reticence to recognize intimate violence make debates about the role of violence in the etiology of mental illness particularly emotional. Historically, academics, psychiatrists and legal professionals have developed sophisticated ways to discount women’s disclosures of violence and abuse, often through claims that women who report this are delusional or in some way mentally unfit.

As trauma studies gain credibility within the fields of psychology and psychiatry, violence against women is now beginning to be understood as having a serious impact on mental health.⁷ Additionally, a body of practice is emerging which directly addresses violence and trauma in a

Health status that is measured only by race and ethnicity may mask the effects of socioeconomic status, diet, education, housing and other factors.

mental health context. Anderson and Chioocchio (1997) provide a useful way of understanding the complex inter-relationship between violence, trauma and mental illness by identifying three categories:

- Mental illness as precipitated by abuse
- Mental illness as a risk for abuse
- Victimization in the mental health system

Mental illness as precipitated by abuse

In the first instance, Anderson and Chioocchio indicate that abuse experiences precipitate entry into the mental health system in several ways:

“Physical and sexual abuse trauma create symptoms which can interfere with normal functioning and which worsen with time. Psychological treatment is often necessary to help the woman integrate her experience, heal damage done to the self and manage overwhelming symptoms. Trauma symptoms are often mistaken for symptoms of major mental illness and viewed as chronic; survivors are then tracked into long-term treatment.” (1997: 29)

What is critical in Anderson and Chioocchio’s statement is the separation of violence and trauma symp-

toms from the symptoms of major mental illness. This distinction is not made throughout the literature, with many researchers suggesting a more direct link between experiences of violence and trauma and the development of a major mental illness. Rosenberg, Drake and Mueser represent a growing acceptance of the latter viewpoint. In their extensive review of the literature they state, “The occurrence of sexual abuse in childhood is increasingly recognized as an important etiologic component in a number of psychiatric disorders” (1997: 260).

This view is in direct contrast with those suggesting that trauma symptoms are misdiagnosed as mental illness. As Harris puts it:

“Much of what gets labeled as symptoms is merely a response to trauma and fear of future abuse.... Accurate assessment of a women’s abuse history may obviate the need for psychiatric diagnosis altogether. Others argue that at the very least, accurate assessment of traumatic events would allow us to revise a number of existing diagnoses, perhaps replacing some of the more severe labels with a diagnosis of post-traumatic stress disorder. In some cases, it might be reasonable to conclude that a woman suffered from both a major mental illness and sequelae of sexual abuse trauma.

When practitioners see these as discrete entities, they are far better able to design interventions to help women cope with and master disturbing symptoms.” (1997: xii & xiii)

As will be seen in the discussion of the findings of this report, this grey area in understanding the role of violence in mental illness continues to confound responses to the problem.

Mental illness as a risk factor for abuse

A concept more universally accepted than mental illness being precipitated by abuse, is that severe and chronic mental illness can put women at risk for abuse. This risk can be a direct result of a woman’s illness and/or the result of medications she takes for her illness (which may impair her judgment, making it difficult for her to protect herself against violent attackers and coercive sex). In fact, abuse of women inpatients by male inpatients has been identified in many psychiatric hospitals (e.g., Riverview Hospital in British Columbia) and raised as a concern for women who are accessing supports in the community, such as clubhouses, which are frequented mainly by men (Morrow, 1999).

The living conditions and co-occur-

rence of substance use problems for many women with mental illness may also contribute to increased vulnerability (Fischer & Breakey, 1991; Drake, Osher & Wallach, 1991; Cuffel, Heithoff & Lawson, 1993). Anderson and Chiochio examine the inter-relationship between abuse, homelessness and substance use:

“The relationship between abuse on the one hand and homelessness, addiction and diagnosed mental illness on the other, is one of mutual causation. Women with a history of multiple abuse are more likely than other women to become homeless, substance dependent and diagnosed with a mental illness. Once women are homeless, substance dependent and psychiatrically symptomatic, they are at greater risk for being sexually and physically abused. Homelessness, substance abuse and having a diagnosed mental illness are thus both outcomes of a history of abuse and risk factors for future abuse.” (1997: 21)

Poverty and chronic stress may therefore make women more vulnerable to physical and sexual abuse (Belle, 1990; Bassuck, 1993). Other studies show strong links between trauma and later substance abuse (Blankertz, Cnaan & Freedman, 1993; Ross et al., 1992) and suggest that women may use substances to self-medicate the psychological

Trauma associated with the care system has been recognized as a serious concern.

symptoms arising from trauma.

Victimization in the mental health system

“There are huge issues around disempowerment – much of what we do is disempowering. We take away their clothes and lock them up and restrain them, plus even if we are trying to do our best to empower them, their illness in itself is disempowering.” (nurse, acute care)

The way in which services are provided to trauma survivors may unintentionally trigger feelings of powerlessness and cause the individual to feel re-traumatized. In most instances this result arises from standard treatment practices which often include physical and chemical restraints. On a more subtle level, “stigmatization and powerlessness are central to the experiences of both trauma and psychiatric hospitalization; betrayal and traumatic sexualization comprise other dynamics of abuse that may be re-enacted in the process of treatment ... [so that] ... treatment providers, even when intending to act in the best interest of the individual, may actually be re-enacting previous patterns of abuse” (Anderson & Chiochio, 1997: 32).

Trauma associated with the care system has been recognized as a serious concern in the British

Columbia mental health system by the former Mental Health Advocate (Hall, 2000). Although there are some instances where the use of restraints may be unavoidable, approaches have been developed that minimize such trauma.

The inter-relationship of all three of Anderson and Chiochio’s categorizations was demonstrated when focus group respondents generally described the relationship between violence and mental illness in a variety of ways. This suggests that recognition of each of the above possibilities, without reducing the understanding of violence and mental illness to any one category, will be most useful.

IV

The Project

The goals of the project were to:

- Document the current practice and training of different groups of mental health care providers in two regions with respect to the provision of services for women with chronic and persistent mental health problems who are survivors of violence and trauma;
- Identify both formal and/or informal protocols and policies that are used to guide service provision in each of the identified settings;
- Identify the critical points of service delivery and nature of services (or lack of) that support or undermine recovery;
- Provide information/consultation to health authorities to assist them to respond more effectively to the diverse needs of women.

The five different mental health care settings where current practice was documented were:

- Mental health care providers who work in inpatient and outpatient settings;
- Mental health care providers in community mental health settings;
- Mental health workers in emergency shelters;
- Peer support workers;
- Service providers who give support to women survivors of violence in the community (e.g., transition house and sexual assault workers).

The latter group of service providers has not traditionally been considered mental health care workers; however, they often serve women with mental illness diagnoses who have experienced violence. Additionally, at the time of the research a three-day symposium brought members of community organizations addressing violence against women together for discussion and training on women's mental health issues.⁸ This allowed the researcher an opportunity to survey this group of women about their current practices and needs with respect to serving women

with chronic mental health problems. This project was also meant to provide an important link to these newly emerging training programs by documenting current practice across service provision sites and fostering the sharing of information. The specific concerns of these organizations are explored in section V, part B of this report.

In planning the research, a number of distinct yet overlapping populations were identified, including:

- Women violence/trauma survivors with mental illness who experience a high degree of functional impairment (i.e., those with serious mental illness⁹) who access mental health services but who do not get resources and support to deal with their experiences of violence;
- Women violence/trauma survivors who also have co-existing substance use issues, street involvement and conflict with the law;
- Women who are re-traumatized in the mental health system and/or become more vulnerable to violence and abuse as a result of their mental health problems;
- Women violence/trauma survivors who have diagnoses of borderline personality disorder or dissociative identity disorder and who (often because of service mandates and resource cutbacks) are unable to

access women-serving organizations (e.g., transition houses) or mental health services.

Methodology

An eleven-member advisory committee was established with representation from women survivors of violence who have been in the mental health system and workers in the five identified sites in both Vancouver/Richmond and the Capital Health Regions. Consultation from practitioners who work with women who have multiple issues (e.g., mental health issues, substance use, street involvement and conflict with the law) was also sought.

The researcher worked with the assistance of the advisory committee to identify representative service providers from each of the identified sites and to develop the themes and questions to be addressed in the focus groups.¹⁰ Questions were given to the service providers in advance of each focus group. The material was analyzed in order to help provide suggestions and policy input relevant to organizations, regional health authorities and the British Columbia Ministry of Health Services.

1. Focus groups and interviews

Eight focus groups and three interviews were held. In total there were 45 participants. Participation across

the five different mental health care sectors was relatively equal with a slightly higher participation from workers in inpatient and outpatient settings. The breakdown is as follows:

- Three focus groups were held (one in Victoria and two in Vancouver/Richmond) with workers in inpatient and outpatient settings. These groups typically had representation from social work, emergency, acute psychiatry, nursing and recreational therapy. One group also had attendance from workers in other parts of the hospital (i.e., acute care and labour and delivery). The total number of participants in this category was 14.
- Two focus groups (one in Vancouver and one in Victoria) were held with emergency shelter workers who serve people with chronic and persistent mental health problems. The total number of participants in this category was eight.
- One focus group in Vancouver was held with peer support workers, and in Victoria an individual interview was held with the co-ordinator of the peer support program in mental health.¹¹ The total number of participants in this category was nine.
- One focus group was held with members of the Health Sub-committee of the Violence Against Women

in Relationships Co-ordinating Committee in Victoria. Additionally, an interview was conducted with two of the mental health members from this committee.¹² The total number of participants in this category was six.

- One focus group with community mental health workers was conducted in Vancouver. The total number of participants in this category was seven.
- An interview was held with a member of the one specialized transition house in British Columbia that works specifically with women with chronic mental health problems.

2. Surveys

In addition to the focus groups and interviews, two surveys were carried out. One was a survey of community organizations addressing violence against women¹³ that was conducted at the three-day Mental Health and Violence Symposium held in Vancouver in October 1999. Thirty-six surveys from both rural and urban settings were completed and included:

- Twenty transition houses;
- Five organizations that identified as either a women's counselling program or a Stopping the Violence Program;
- Six sexual assault centres;

- Five specialized victim assistance programs.

The second survey was a smaller one that was meant to confirm our understanding that very few specific programs on violence and trauma are offered through mental health services in British Columbia. This survey involved a letter that went out to all mental health managers in the British Columbia health regions asking them to provide information about any programs that they provided. Twenty managers were contacted, and six responded with information.

V

Many mental health professionals are reluctant to acknowledge the role of violence and trauma in women's lives.

Findings

A. Current Practice in British Columbia

This section summarizes current practice in the mental health system for working with women with chronic and persistent mental health problems who are survivors of violence. Data from the two regions where focus groups were conducted (Vancouver/Richmond and the Capital Health Regions) is emphasized. However, where it is relevant, information from other regions in British Columbia gathered from the survey is also included.

1. The need for a gender analysis

Experiences that are often central to women's lives are routinely overlooked in policy development, mental health planning and in practice and educational manuals.¹⁴ Attention to the particular life experiences of women (e.g., caregiving and family responsibilities, economic insecurity and experiences of violence and abuse) is critical for understanding mental illness and for assisting women in recovering and maintaining wellness.

Focus group participants indicated that many mental health professionals are reluctant to acknowledge the role of violence and trauma in women's lives, either downplaying its significance, or seeing it as an issue separate from mental health. The result is that current assessment tools and treatment plans do not regularly take violence and trauma into account. These practices severely limit the ability of the mental health system to respond effectively to women and may result in misdiagnoses or lengthy delays in getting women the supports they need.

In the focus groups it was clear that most mental health care providers, regardless of where they were located, recognized that they were not meeting the needs of women survivors. Although there were a few exceptions, generally the care of this group of women is not specialized and very few specific programs and protocols have been developed to work with them.

Violence and trauma have implications for women regardless of their diagnosis.

It is now widely recognized that planning and treatment in the mental health system must be guided by a “bio-psycho-social” paradigm. An application of this paradigm to treatment and practice means recognizing the social factors that affect peoples’ lives and their experiences of mental illness and mental wellness. A recognition of gendered social factors reveals that men and women sometimes have different kinds of experiences and when they do have the same experiences they may be impacted differentially. A gendered analysis of violence, for example, reveals that women are more often the targets of intimate violence across the lifespan than men. Applying a gendered analysis, therefore, is consistent with a “bio-psycho-social” model and has the potential to assist in refining policy, services and programs so that they are able to meet the unique needs of women and men.

2. Mandates and diagnoses

There are significant differences in approaches to client treatment in each of the mental health service sectors. Those working in inpatient and outpatient hospital settings, and to a lesser degree those working as part of a community mental health team, described their treatment as driven by current policy mandates that direct the bulk of the system’s

resources to individuals with serious mental illness. Although the British Columbia Mental Health Plan stipulates that serious mental illness should be determined by functional impairment, currently in the system it is determined primarily by diagnosis. That is, hospitals, psychiatric institutions and community mental health teams are mandated to work primarily with people who have Axis I diagnoses.¹⁵

Violence and trauma have implications for women regardless of their diagnosis. However, when diagnostic criteria are used as a method of gatekeeping for access to services, a number of specific problems are caused for women with experiences of violence and trauma.

For example, many of the symptoms associated with histories of severe trauma and abuse are consistent with symptoms that result in Axis II diagnoses, especially borderline personality disorder, dissociative identity disorder, eating disorders and post-traumatic stress disorder. Although there were some exceptions to this, especially among the community mental health teams, generally respondents felt that mandate restrictions meant that they were not able to adequately treat women with Axis II diagnoses. The result is a screening process which may unintentionally affect the ability of

violence and trauma survivors to access services. Respondents spoke about clients with Axis II diagnoses being refused hospital or community mental health services, resulting in an overuse of emergency services in attempts to get assistance.

A broader problem is that many women with serious and chronic mental health issues do not have adequate incomes, support systems or housing. This means that women who do get access to inpatient care in hospitals are often, once stabilized, released to the streets or to emergency shelters. Many of these women repeatedly end up in emergency rooms, in part because their living conditions make it difficult to maintain treatment programs or work towards recovery. In the absence of support services, a large proportion of these women self-medicate with drugs and/or alcohol.

On the other hand, throughout the system there appears to be an erroneous assumption that experiences of violence and trauma produce symptoms that are only consistent with Axis II diagnoses. This can lead to women's experiences of violence and trauma being overlooked altogether if they have an Axis I diagnosis.

In contrast, those working in emer-

gency shelters and peer support groups described their approach as one that responds to the client's presenting behaviours rather than to her previous diagnosis. Despite this, these services did not necessarily provide specific supports to trauma and violence survivors and some of them had mandate or resource restrictions which made it especially difficult to work with these women. For example, they did not have specific training in how to work with trauma survivors or enough staff to deal comprehensively with trauma survivors.

Throughout every focus group it was generally agreed that the client groups that were most without services were those women diagnosed with borderline personality disorder. This was not solely the result of service mandates, but rather reflected the view that the behaviour accompanying this disorder is so difficult to work with that this client group was often considered untreatable, and therefore discriminated against more than any other. One community mental health provider stated, "In my experience [borderline personality disorder] is almost the kiss of death diagnosis." Nevertheless, there are some specialized services for this group of clients, for example, the outpatient Integrative Personality Program at Vancouver General Hospital and a

program at the Dual Diagnosis Clinic in Vancouver. Although both of these programs draw on the work of Marsha Linehan, a noted specialist in the area of personality disorders and trauma, they do not have groups specific to women and men, and do not necessarily work directly on violence and trauma issues.

Providers working with the community mental health teams in Vancouver noted that sometimes geographic restrictions exist with respect to who can access services from a particular team. In some cases this has resulted in a loss of continuity of care for women who may be developing relationships with providers that would enable them to comfortably disclose their experiences of violence, but who must change providers as a result of a move.

Mandate restrictions are intricately linked to inadequate resources in the mental health system. Providers felt that they were often called upon to make decisions about treatment access based on diagnosis, current client load or hospital bed availability, rather than on a client's condition.

3. Is addressing violence “counter-therapeutic”?

Although not all service providers in the focus groups were identifying women with trauma and violence

experiences, the majority recognized the prevalence of violence in their clients' lives. Providers who were most likely to recognize this were those working outside of inpatient settings. This appeared, in part, to be a result of the different functions of services. Those working in inpatient settings were more likely to see their role as one of initial assessment and stabilization. In this setting, providers often felt it was inappropriate and even counter-therapeutic to delve into their clients' histories.

Two points are significant here: one is the prevailing belief that trauma must be treated separately from serious mental illness, and the second is the pragmatic recognition by many workers that without specific programs and supports in place for women, it is not possible to begin addressing trauma histories.

Women with serious mental illness were described as “psychologically vulnerable” and the belief was expressed that if violence were not the presenting issue then “digging up the past can not only be discouraged because it would stand in the way of dealing with things that are current, but it can also seem less compassionate because it is too much for [women] ... because of past hurts that need healing” (acute psychiatry inpatient social worker). This view was reinforced for some practitioners

Community mental health workers also sometimes voiced the view that women, especially those with co-existing substance use issues, needed stabilization before their histories of trauma could be explored.

who had tended to women who were receiving private therapy for early childhood abuse and ended up in psychiatric crisis. To some extent, the literature supports this view in that trauma specialists suggest that women need sufficient ego strength and support to begin exploring traumatic life events (Linehan, 1993). However, in the context of our study, providers linked this view not only to a lack of resources and program supports but also to fear, misunderstanding and lack of training among providers in addressing violence.

Staff indicated that if past trauma and violence were noted as part of the intake and assessment process, then hospital social workers usually became involved and attempts were made (often unsuccessfully due to lack of services) to connect clients with community-based supports. The only exception to this practice was in the case of clients who came into emergency directly as a result of a recent physical or sexual assault. If violence were considered the primary concern, clients were referred to the hospital's violence against women in relationships program or sexual assault program (if one was available). Additionally, in at least one hospital, there was an outpatient group that addressed adult experiences of sexual trauma.

Community mental health workers

also sometimes voiced the view that women, especially those with co-existing substance use issues, needed stabilization before their histories of trauma could be explored. They concurred that bringing up a woman's past history of trauma is damaging if she is unable to access long-term support. In fact, some workers were concerned that if service mandates expanded without further resources, their own capacities would be stretched beyond the limit.

Emergency shelter workers in co-ed facilities recognized that the vast majority of their clientele had traumatic life experiences. Many of these services provide housing to people with multiple issues – poverty, homelessness, mental illness, trauma histories and health problems such as HIV and Hepatitis C. As a result, especially with the larger shelters, the focus is on providing people with the supports they need in the immediate moment. This often precludes any concentrated support for trauma and violence survivors. Despite this, some workers indicated that because they work with people over longer periods of time, they are more likely to develop a trusting relationship with their clients. Specialized shelters were more able to provide supports to women. Peggy's Place in Vancouver, for example, has a mandate specifically to work with

women who have serious mental illness diagnoses and experiences of violence and trauma. Sandy Merriman House in Victoria works with “high-risk” women who have mental health and/or substance use issues, most of whom are trauma survivors.

4. The need for training

Mental health providers in our study indicated that they had very few training and education opportunities on the topic of violence against women, either in their respective professional schools or in their practices. Those programs and opportunities that do exist are not systematically required as a criteria of mental health training. Providers specifically identified the need for training that addresses the interconnections between violence, trauma, mental health and substance use.

Despite this, many providers have tried to influence their agencies and have sought out training and information opportunities. One such opportunity is the program at the Justice Institute in Vancouver called “Understanding and Responding to Child Sexual Abuse in the Seriously Mentally Ill.” However, many providers had not been able to gain access to this program, especially those working in emergency shelters or peer support programs where training budgets are small or

non-existent.

Additionally, a group of concerned community mental health workers in Vancouver is now meeting regularly to discuss women’s mental health issues in an attempt to better serve their clients. Links between some of the members of this group have helped at least one co-ed shelter in Vancouver obtain some training for its workers. Furthermore, at the time of writing, the Vancouver/Richmond Health Board had just hired a trainer to do workshops on trauma with new staff in the mental health regions. Other workers spoke about how their involvement in local Violence Against Women in Relationships Coordinating Committees, which bring together practitioners from across a broad range of service sites, increased their understanding of the issues.

In Victoria, focus group participants who worked in the hospital in labour and delivery had had access to training. Although this training did not specifically address the needs of women with chronic and persistent mental health problems, staff indicated that it had greatly improved their confidence in working with pregnant women and mothers who were currently in abusive relationships or who had past histories of violence and trauma. They pointed out that the training they had re-

Practitioners identified the need for programs that take into account the experiences of specific groups of women.

ceived de-emphasized case-finding and instead focused on educating staff and addressing attitudes towards violence with the goal that staff would then be better equipped to create an environment where women would feel comfortable disclosing and seeking supports.¹⁶

It was recognized that during emergency psychiatric treatment it was often difficult, and in some cases inappropriate, to delve into trauma histories. Therefore, some professionals felt that a good place to start would be to help staff recognize the ways in which psychiatric treatment can be re-traumatizing, especially to women with experiences of violence, and to then work toward helping women get connected to the appropriate outpatient groups and community-based resources. On the latter point, it was felt that education of hospital staff who would bring community-based organizations to the hospital to discuss the resources available for women would help bridge the gap between the hospital and the community and provide better continuity of care for women.

Providers also felt that systems needed to be set up in hospital to help ensure that women's trauma and violence histories are recorded in their charts and that appropriate supports and follow-up are provided.

To help facilitate this, providers in the hospital working outside of psychiatric units wanted access to mental health resource people who could assist with discharge planning.

Across the board, practitioners wanted ideas about how to shift current practice without increasing workloads and about how to implement changes without requiring a wide range of new resources.

5. The need for specialized programs

Practitioners identified the need for programs that take into account the experiences of distinct groups of women. Specifically, the concerns of Aboriginal women, women who are immigrants and refugees and women in prison were mentioned.

For Aboriginal women, the importance of recognizing the legacy of colonialism and extreme experiences of abuse that have resulted from the residential school system were highlighted. For refugees, experiences of torture and extreme trauma were discussed and better links between organizations working with refugees and mental health were suggested. It was observed that new immigrants rarely have access to culturally specific supports and that there is a dearth of translation and interpretation services to bridge language and cultural barriers to

services.

A review of services at the Burnaby Correctional Centre for Women done by the Forensic Psychiatric Services Commission in 1993 identified the need for programs that address women's experiences of abuse and violence. To date, no comprehensive program addressing these issues has been implemented.

In order to ensure support and resources for existing initiatives and for the development of new programs, active support from directors of mental health and mental health managers is required. Women with expertise in working with violence and trauma survivors and with specific populations must be employed in the mental health system, and support and acknowledgement for women already engaged in this work should be ongoing.

Further to this, support from the British Columbia Ministry of Health Services and its provincially funded community mental health organizations¹⁷ is also needed. Additionally, cross-Ministry co-operation is necessary to ensure recognition and financial support for these initiatives. Continued co-ordination between the work of Ministries and the work of specialized committees on women's health (e.g., Vancouver's Women's Health Planning Implementation Committee) is needed. Finally, more

research is needed which can provide information to mental health planners to assist in program development and resource allocation.

B. The Role of Community Organizations That Work with Survivors of Violence

Although our study focused on gathering information from services in the mental health system, it was evident from the outset that community organizations play a key role in supporting women with trauma and violence histories. Historically, community organizations addressing violence against women were established to fill gaps in existing services and offer an alternative support model informed by women's lives and specific experiences. Currently, service demands and lack of training with respect to working with women diagnosed with mental illness mean that some providers in these organizations have found that they are unable to meet the needs of women who have chronic and persistent mental health problems. Services that are able to accommodate this group of women often have long waiting lists.¹⁸

In this research study, we had the opportunity to conduct a survey at a three-day workshop which took place in Vancouver in the fall of 1999 and brought women from transition houses, women's centres, sexual

Women spoke about the barriers that they felt made it difficult to provide services to women with chronic and persistent mental health problems.

assault centres and victim services together for training on mental health issues. Additionally, one focus group was held in Victoria with members of the Health Sub-committee of the local Violence Against Women in Relationships Co-ordinating Committee. This particular group was chosen for a focus group because it was actively involved in coalition work with mental health services in their region.

The purpose of the survey was to assess whether these organizations were in fact providing a level of service to women with serious and chronic mental health problems. Further, the researchers wanted to better understand the kinds of supports organizations would need to provide services to this population.

The results of the survey show that organizations are getting requests for services from women with serious mental health problems, with sexual assault centres reporting the highest number of women from this population. All of the organizations surveyed indicated that they served this population, but many indicated they could only do so if certain conditions were met (e.g., the woman was drug and alcohol free, they could meet the woman's needs, the woman was capable of living independently and was not a threat

to others using their services.).

Women spoke about the barriers that they felt made it difficult to provide services to women with chronic and persistent mental health problems. Chief among these were lack of staff time to deal with the complex needs of women, inadequate training on mental health issues, and fears and misperceptions about the behaviours of women with mental health problems. Transition house workers, because of the live-in nature of their service, more frequently expressed concern for the safety of other residents and children, or indicated that communal living was not the best arrangement for women with mental illness. Overall, workers indicated that the needs of this population of women often differ from the needs of other women, and this could make it difficult to provide good services, especially with limited resources. For example, women's medications could make it difficult for them to participate in group activities or in the one-on-one counselling and advocacy services provided by some organizations.

Few workers indicated that they had had any formal training with respect to mental health issues. The training that women did list was not extensive and usually included the occasional workshop that women pursued on their own, or a speaker coming to

their organization. One exception to this is a training module designed by the British Columbia and Yukon Transition House Society, which is specifically designed to help providers work with women with chronic and persistent mental health problems.

In most of the organizations surveyed, staff had some interaction with mental health organizations (especially emergency services) but it was rare for there to be formal relationships or collaborations. Part of the reason for this may be the philosophical differences between mental health services (which work from a medical model) and community organizations working on violence against women (which work from an empowerment framework).

Some workers in this sector indicated that they felt they were being used by the mental health system as a solution for women who really were in need of more intensive long-term care. In these instances, an under-resourced mental health system which does not recognize the specific needs of this group of women was cited as the problem.

Overall, workers wanted to be able to maintain the uniqueness of their services (e.g., working from feminist frameworks) but were in many cases eager to establish better

connections and links to mental health in order to provide more comprehensive supports to women with chronic and persistent mental health problems.

C. Innovative Practice and Programming

The following section outlines programs and practices identified as useful by service providers for working with women violence and trauma survivors diagnosed with mental illness. In addition, where appropriate, information is included about other programs throughout the regions in British Columbia.

1. Women-only services

Focus group participants supported the development of more women-only programs in mental health generally, and specifically backed women-only groups for violence and trauma survivors.

For example, although some services do not directly address women's trauma and violence histories, they were seen as providing important additional support for women. Specialized shelter services such as Peggy's Place in Vancouver and Sandy Merriman House in Victoria do not provide long-term counselling for violence and trauma survivors, but were seen as critical for mentally ill and substance-using

Peer support programs were viewed as an essential component of the mental health system.

women trying to leave abusive relationships and who might not be able to get access to regular transition houses. Along these lines, a permanent housing project supported by the Mental Patients' Association in Vancouver (Kidder's Place) for women with mental illness who are mothers also fills a critical housing gap for women with children. Additionally, staff at the Kettle Friendship Society, a drop-in centre in Vancouver, have managed to institute and preserve a small woman-only space to encourage women to attend who might not be comfortable or feel safe in co-ed environments. Women using this service have requested a women-only drop-in time at the centre.

2. Peer support services

Peer support programs were viewed as an essential component of the mental health system, and as a good place to address violence and trauma issues through the use of specially trained peer support people. There are several peer support programs in both Vancouver and Victoria, although only the program at the Vancouver/Richmond Mental Health Network provides groups specifically for women. During the time that the focus groups and interviews were conducted, the peer support program in Victoria was in the process of re-designing its training; the co-

ordinator indicated there were plans to incorporate training related to trauma and violence survivors.

3. Violence-specific mental health programs

In a survey of six other regions in British Columbia¹⁹ it was determined that most regions do not have specialized mental health services for women diagnosed with mental illness who have violence and trauma histories. The mental health managers in these regions reported that women were provided services through existing programs, most of which were co-ed and did not deal with violence and trauma specifically. Although most of the regions did have women-specific supports in the community (e.g., transition houses, sexual assault services) not all of these services were equipped to work with women with chronic and persistent mental health problems.

There were exceptions to this. In Mission, for example, mental health services and women's support services are located in the same building, which has allowed for links between services to develop. This has resulted in counselling and support groups being available to women trauma survivors who experience depression, anxiety, adjustment disorders, post-traumatic stress and personality disorders (women who are in an active psy-

In most programs, violence and trauma are addressed either one-on-one by an individual mental health care worker or through a referral to a women's organization in the community.

chosis are not able to be referred to these services). This kind of collaboration is evident in other regions, most notably in Williams Lake, where alliances between the women's centre and the local consumer organization are strong.

In most programs, violence and trauma are addressed either one-on-one by an individual mental health care worker or through a referral to a women's organization in the community. There were, however, a few exceptions to this. In the Vancouver/Richmond Health Region, for example, there is one community mental health worker whose time is dedicated primarily to working with women who are trauma survivors. The Dual Diagnosis Program in Vancouver holds groups based on a model developed by Marsha Linehan, which assists trauma survivors with containment and coping strategies until they are able to work more extensively with a therapist. Additionally, some hospital outpatient programs (e.g., Richmond Hospital) have programming for survivors of sexual trauma experienced as an adult.

Aurora is a program at British Columbia Women's Hospital for women with substance use issues that builds support around violence and trauma issues. With respect to women with substance use prob-

lems, harm reduction models were generally supported, especially those that would allow these women to access supports in the community to work on issues related to violence prior to becoming alcohol or drug-free.

With respect to pregnant women with histories of violence and trauma, or women who are experiencing postpartum depression, the Reproductive Mental Health Program at British Columbia Women's Hospital provides clinical treatment, counselling and support. However, women working in this program emphasized the need for long-term counselling for this group of women and highlighted the need for more services.

4. Gendered policy and practice initiatives in mental health

Several policy and practice initiatives that have emerged over the last number of years illustrate a growing awareness of the long-term impact of violence and trauma on women. Not all of these initiatives specifically identify women with chronic and persistent mental health problems as a unique population; however, evidence of collaboration across initiatives is encouraging.

The results of an extensive consultative process in Vancouver (the Women's Health Planning Project) that brought together health care

professionals, researchers and community-based workers were released in January 2000. This report separately identified violence against women and mental health as key planning priorities for the region (Vancouver/Richmond Health Board, 2000). The report led to an adoption of a gender lens policy, which stipulates that policy and planning in the region must be informed by a gender analysis.

Coming out of this process and the release of the report, “Moving Towards Change: Strengthening the Response of British Columbia’s Health Care System to Violence Against Women”, the British Columbia Women’s Health Bureau supported the development of a “tool kit” to assist health and mental health planners in being more responsive to issues related to violence against women in their regions (Morrow & Varcoe, 2000).

As mentioned, community mental health workers in Vancouver have formed an ongoing committee that brings members of the mental health teams together to discuss women’s issues and to influence policy and practice in mental health.

With respect to programming and training, several initiatives are currently underway. In Victoria, a group of providers from organizations addressing violence against

women and from mental health services began meeting in 1998 to discuss how to improve mental health services to women. This group secured funding from the British Columbia Ministry of Health Services to develop a two-year domestic violence screening pilot project aimed at assisting mental health care workers in identifying and responding to victims of domestic abuse. This program was piloted in the short-term psychiatric assessment unit at Eric Martin Pavilion in Victoria.

In Vancouver, a trainer has been hired to train new staff in the mental health regions on issues related to trauma. Plans are underway to extend this training to existing staff and to make it compulsory (i.e., to adopt it as a “core competency”).

At Riverview Hospital, following a study which illustrated the prevalence of past trauma experiences in the inpatient population (Fisher, 1998), there was an attempt to set up programming, beginning with the development of training modules for staff. This initiative was terminated before the project was complete. In the fall of 2000, however, a new committee (the Vulnerable Patients Task Committee) was initiated to guide the development of staff-wide training on avoiding re-traumatization of clients²⁰ with violence and trauma histories, approaching disclosures

A group of practitioners at Vancouver General Hospital has been meeting to develop a proposal seeking support for the establishment of an outpatient post-traumatic stress disorder clinic.

and assisting survivors with coping and containment strategies. Part of this training was also aimed at helping clients learn ways to stay safe, both inside Riverview and upon discharge. This initiative is especially significant because the long-term goal is to build capacity within the hospital to provide specific programming to female and male trauma and violence survivors.

To help support clients once they have left the hospital, a group of practitioners at Vancouver General Hospital has been meeting to develop a proposal seeking support for the establishment of an outpatient post-traumatic stress disorder clinic. In the planning stages, two of these practitioners met with a wide range of women-serving organizations from the community and with practitioners from hospital-based domestic violence and sexual assault programs to ensure the relevance of this clinic for women.

As already discussed, in October 1999, a conference sponsored by the British Columbia Specialized Victim Assistance and Counselling Program, the British Columbia and Yukon Society of Transition Houses, and the then British Columbia Ministry of Health, the British Columbia Ministry of the Attorney General, and the Ministry of Women's Equality brought together transition house

workers, specialized victim assistance workers and sexual assault workers for a three-day training session focused on providing services to women diagnosed with mental illnesses. This initiative was key in the process of strengthening links between mental health and organizations in the community addressing violence against women.

The Women and Mental Health Demonstration Project Program²¹ allowed groups in four regions of the province to develop innovative women-centred programming in mental health. One project out of the West Coast Mental Health Team in the Simon Fraser Health Region in Vancouver designed specialized programs for women trauma survivors who have been diagnosed with developmental disorders and mental illness.

Most recently, the British Columbia Ministry of Community, Aboriginal and Women's Services is in the process of developing a project designed to better understand and address the overlapping needs of women with mental illness, substance use problems and experiences of violence. The proposal for this work was recently released to a range of community-based organizations and mental health and addictions workers for feedback at a meeting held at the British Columbia

Centre of Excellence for Women's Health in May 2002.

D. Conclusion

“There’s a higher message I believe in all this and it’s that the true nature of the human spirit is not to walk around banged up and beat up by horrific circumstances that are either historical, familial, or accidental but to transcend them – and our task as helpers, as researchers, as educators, is to recognize that, to acknowledge it and do everything we can to put ourselves out of business.” (John Wilson, American psychologist and International Society for Traumatic Stress Studies past president, 1995, cited in Reilly, 1997: 247)

Despite a growing body of research that illustrates the impact of violence and trauma on women’s mental health, few programs designed to meet the needs of women with chronic and persistent mental health problems exist in British Columbia. This is especially true for women with diagnoses of borderline personality disorder, women with co-existing substance use and mental illness, women in prison, women with developmental disabilities, and Aboriginal, immigrant and refugee populations. The current research illustrates that within the mental health system, treatment is still provided predominantly through a

bio-medical treatment paradigm, which has hindered the ability of the mental health system to respond appropriately to women who are survivors of violence and trauma. Further exacerbating this is the lack of recognition, within the current system, of gender inequities as critical social determinants of mental health.

At the same time, many individual mental health practitioners recognize the impact of violence on their clients but often feel unable to provide adequate support because of lack of training and mandate and resource restrictions within the mental health system. A related problem is the difficulty of accessing specialized services for women in the community. That is, community-based practitioners often lack experience working with women with chronic and persistent mental health problems and their services are often over-burdened and under-resourced.

Despite these barriers, there was also evidence of an emerging sensitivity in mental health to the needs of women violence and trauma survivors. This was illustrated by the development of several initiatives that are attempting to address mental health practitioner training. On a health policy and planning level, there was evidence that violence against women is being recognized as a

serious health concern for women. What is lacking, however, is a clear commitment in mental health to systematically addressing the impact of violence and trauma on the mental health of women with chronic and persistent mental health problems.

Several key principles were identified as necessary for working with women with chronic and persistent mental health problems who are trauma and violence survivors. These include the adoption of a bio-psycho-social practice model, the development of women-centred programming and supports that directly address violence and trauma, and closer collaboration between the mental health sector and community organizations addressing violence against women.

In order to strengthen and build on existing initiatives, mental health policy makers and planners must provide leadership in developing training and practice guidelines. Innovative programming in other jurisdictions should also be used as a source of information and support.

VI

Recommendations

A. Gender Lens Tools

- It is recommended that a gender lens policy be adopted by British Columbia health authorities. Several gender lens tools currently exist which should be utilized, including one specifically designed for mental health directors and managers²² and one designed specifically on violence against women.²³
- It is recommended that the provincial government and health authorities plan programs and develop policy addressing issues of trauma, using an integrated model that draws on both bio-medical and social justice understandings of violence and trauma.

B. Process/Integration

- It is recommended that the Ministry of Health Services, the Minister of State for Mental Health and the Minister of State for Women's Equality provide leadership to health authorities in identifying violence and trauma as serious concerns for many women with mental health problems.
- It is recommended that the policy statements and responses to violence against women with mental health problems be integrated into Best Practices Guidelines and other policy guidelines affecting mental health and addictions.
- It is recommended that the Ministry of Health Services, the Minister of State for Mental Health and the Minister of State for Women's Equality develop accountability mechanisms and performance indicators that will assist in evaluating and monitoring progress at the regional level.

C. Collaboration

- It is recommended that the Ministry of Health Services and the Ministry of Community, Aboriginal and Women's Services continue to support programs that work with women who are survivors of violence and who have mental health problems.
- It is recommended that there be collaboration between provincial

health authorities (including the Provincial Health Services Authority) on issues specific to women who are survivors of violence and have mental health problems.

D. Training Mental Health Care Providers

- It is recommended that as part of the Ministry of Health Services' commitment to professional education, they provide education assisting health care providers to assess and support violence and trauma survivors, including strategies to minimize re-traumatization in the mental health system. It is recommended that this curriculum build on existing materials and the models developed and included in this report's inventory.
- It is recommended that workshops designed to train mental health workers include the expertise and involvement of anti-violence workers.

E. Program Development

- It is recommended that health authorities consult with the British Columbia Association of Specialized Victim Assistance and Counselling Programs, the British Columbia and Yukon Society of Transition Houses and other provincial anti-violence organizations to draw on their expertise in the area of violence against women.

- It is recommended that health authorities evaluate and monitor services and programs to ensure that they are responsive to the needs of women with mental health problems who have trauma histories.

- It is recommended that health authorities pursue creative strategies to address the long-term counseling needs of women who are survivors of violence and abuse.

- It is recommended that health authorities address the needs of women with diagnoses of borderline personality disorder, women in prison, women with developmental disabilities, Aboriginal women, and women in immigrant and refugee communities.

F. Further Research

- It is recommended that the Gender and Health Institute of the Canadian Institutes of Health Research should make violence against women with mental health problems a strategic priority.

- It is recommended that the Gender and Health Institute of the Canadian Institutes of Health Research provide national leadership with respect to innovative program development and evaluation in order to better understand what kinds of programs/supports work best for women.

- It is recommended that the value of

participatory action research frameworks for conducting research on violence and mental health be recognized.

- It is recommended that support be provided for research that explores more systematically the role of violence and trauma in the etiology of mental illness.

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APPENDIX 1: Focus Group Questions

A. Background Information

1. What groups of clients does your organization serve? Are these broken down into any particular categories for program planning and treatment?
2. Are there different practices/policies/resources for working with the different categories of clients you have identified?

B. Current Practice/Training

1. Are there any current practices in your organization with respect to providing supports to women diagnosed with serious mental illness?
2. Are there any current practices in your organization with respect to providing supports to women diagnosed with serious mental illness who have histories of trauma and abuse?
3. Have you received any training in your agency on mental health issues as they relate specifically to women?
4. Have you received any training in your agency on violence?
5. Is there training that looks at the overlapping issues between violence, trauma and mental health?
6. Are you aware of any specific policies and/or procedures on working with/supporting survivors of violence and trauma?
7. What supports are available in the community to assist women who are survivors of violence?
8. Are these supports available to women with serious mental health problems?
9. What is the response of these services when you try to refer someone with mental health issues?

C. Barriers

1. What are some of the barriers that exist with respect to working with women diagnosed with serious mental illness who are violence and trauma survivors?

D. What is Needed

1. What kinds of practices/supports have you found to be helpful to women?

2. What kinds of support do you think women who have been diagnosed with serious mental illness who are violence and trauma survivors need?

3. What would these services look like? What would their nature be?

4. What would you say are the critical points of service delivery for this group of women?

5. What kinds of support/information/tools do staff need to begin addressing this issue?

E. Capacity/Readiness

1. What kinds of practices do you think you could realistically incorporate into your work setting immediately?

2. What might some realistic long-term goals towards supporting this group of women?

3. If your organization was going to

improve or initiate programs, what would the process be?

4. What support would there be for such change in your organization?

5. How might support be fostered for such programs and initiatives?

6. What kind of recommendations do you have for changes in other services that might help you in your work?

APPENDIX 2: Survey for Community Organizations That Work with Survivors of Violence

1. Please indicate the type of organization you represent (i.e., transition house, specialized victim assistance, sexual assault centre).
2. Briefly describe your role in the organization.
3. Where is your organization located (indicate whether you work in an urban or rural context)?
4. How long have you worked in your present organization?
5. How long have you worked with women survivors of violence and trauma overall?
6. How frequently do you get women requesting services who have serious and chronic mental health problems (i.e., women who you feel inadequate to assist because of the complexity of their problems)? For example, how many of these women might you see a month?
7. Do you currently provide services to women with serious and chronic mental health problems?
8. What are some of the barriers to providing services to women with serious and chronic mental health problems?
9. Does your organization have any formal protocols/guidelines with respect to working with women with serious and complex mental health problems?
10. Have you ever received training in your organization about how to work with women with serious and complex mental health problems? Specify what kind of training.
11. What kind of supports (e.g., training, information, staffing, formal liaison with mental health workers, etc.) would you need to better provide services and support to women with serious and complex mental health problems?
12. Additional comments?

APPENDIX 3: Selected Innovative Programs and Resources

In addition to documenting programs, practice and resources in British Columbia, we also collected information from other cities in Canada and the United States. This documentation is not exhaustive, but rather represents a selection of resources that were available at the time this report was written. The inclusion of the following resources in this report should not be seen as an endorsement of specific programs and practices, since many of which have not yet undergone systematic evaluation. Rather, we encourage readers to seek out these and other resources and critically consider their applicability to their particular mental health settings.

A. CANADIAN PROGRAMS AND RESOURCES

Women Recovering from Abuse (WRAP)

A program of the Centre of Addiction and Mental Health and Sunnybrook and Women's College Health Sciences Centre and partnered with the Centre for Research in Women's Health
Toronto, Ontario
(416) 323-6010

This program offers a six-week/half-day program of group and individual counselling to women who have experienced abuse and who have sought psychiatric treatment in the past. It is covered by Ontario Health Insurance Policy. WRAP also provides education to health care professionals and community agencies. WRAP conducts research on the impact of trauma on women to determine effective treatment.

Women's Health Centre

St. Joseph's Health Centre
Toronto, Ontario
(416) 530-6208

This program is open to women with psychiatric histories, uses a non-medical model and prioritizes women who are not in a position to pay for therapy/counselling and who are marginalized by discrimination, vio-

lence and lack of access to services. It provides open-ended therapy and group work mainly around issues of childhood trauma.

**Toward Empathy: Access to Transition Houses for
Psychiatrized Women**

Gisela Sartori. Second Opinion Society for the Family Violence Prevention Division Health Canada, 1995. Whitehorse, Yukon

A manual designed to promote equal access to transition houses for women with psychiatric diagnoses. This manual begins by looking at the experiences of women who have been labelled mentally ill and goes on to provide specific strategies to be used by transition house workers in supporting this group of women.

Ruth Gallop and Barbara Everett Website

www.gallopandeverett.com

Ruth Gallop and Barbara Everett are two professionals with extensive experience in the provision of clinical services with a specific emphasis on women's mental health. Their website provides information relevant to a wide range of practitioners, including lists of resources and training materials.

B. PROGRAMS UNDER DEVELOPMENT IN BRITISH COLUMBIA

The Vulnerable Patients Task Committee

Riverview Hospital, Port Coquitlam, BC
(604) 524-7206

This committee has been established to assist in the development and implementation of a hospital-wide training program for all staff. The training is focused on helping staff avoid the re-traumatization of clients during the course of treatment, assisting them in approaching disclosures of violence and trauma, and helping them teach clients coping and containment strategies to deal with violence. The long-term goal of this initiative is to build capacity within the hospital to provide specific programming to trauma and violence survivors.

Improving Mental Health Outcomes for Women Diagnosed with

Serious Mental Illness and Mental Retardation/Developmental Disabilities Who Have Violence and Trauma Histories

Simon Fraser/West Coast Mental Health Support Teams
Simon Fraser Health Region, Vancouver, BC
(604) 660-0786

This is a demonstration project, supported by the British Columbia Ministry of Health Services and coordinated by the British Columbia Centre of Excellence for Women's Health, which developed treatment programs and support groups for women who have dual diagnoses of mental illness and developmental disabilities and who are also survivors of violence and trauma.

Vancouver Coastal Health Authority

Training Module on Trauma
Vancouver/Richmond Health Board, Vancouver, BC
(604) 736-2033

In Vancouver, a manual has been developed to train new staff in the mental health regions on issues related to trauma. At the time of this study, plans were underway to extend this training to existing staff and to make this training compulsory (i.e., to adopt it as a "core competency").

Vancouver Community Mental Health Women and Mental Health Committee

Mid-Town Mental Health Team, Vancouver, BC
(604) 872-8441

This committee brings together practitioners working on community mental health teams in the Vancouver area to discuss women's mental health issues.

C. AMERICAN PROGRAMS AND RESOURCES

Maine Department of Mental Health, Mental Retardation and Substance Abuse Services

411 State Office Building, Station 40
Augusta, ME 04333
(207) 287-4223

This department has produced a number of action plans, sponsored conferences and published reports related to working on trauma and violence issues in mental health. The following two reports are recommended:

- Comprehensive Strategic Action Plan for Creating a System of Care Responsive to the Needs of Trauma Survivors

Ann Jennings

This report outlines a plan of action for the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services with respect to providing services for women who have co-existing substance use and mental health problems. It focuses on building the strength of local, regional and state-wide networks to develop policy and services.

- In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed for Trauma Services

Maine Trauma Advisory Group Report, 1997

This report presents information from a needs assessment which was conducted over nine months by the Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Trauma Services. The study involved 127 trauma survivors who were past or present public mental health service recipients and 122 professionals who were recommended by survivors. The report primarily shares the experiences of trauma survivors and trusted professionals with respect to “what hurts” and “what helps” their recovery.

Community Connections Mental Health Clinic

Washington, DC

This centre provides closed groups for women mental health clients who have case managers or therapists. It also has groups for women who are mothers, women who are abusive and incarcerated women.

Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness

Maxine Harris with Christine Landis (Eds.)
Amsterdam: Overseas Publishers Association, 1997.

This book provides a wide range of articles on the issue of violence and mental health. It is broken down into several sections: Theory and Assessment, Treatment, First-person Accounts, Policy and Research, Special Issues. Much of the work is written by authors who work at Community Connections, a private non-profit mental health clinic serving women and men in the District of Columbia. The agency provides a range of services including case management, supported living, individual and group counselling, and vocational placement to female and male clients with a history of mental illness, substance addiction and homelessness. Since the early 1990s all clinical work at Community Connections has been informed by the knowledge that many, if not most, of the clients have experienced severe and multiple traumas both in childhood and adulthood.

Trauma, Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups

Maxine Harris and the Community Connections Trauma Work Group
New York: The Free Press, 1998.

This book was also developed by the people involved at Community Connections and provides specific guidance for working with women with co-existing substance use and mental health problems.

The Trauma Assessment and Treatment Resource Book

The Design Centre
44 Holland Avenue, Albany, NY 12229
Fax (518) 473-2684

A compilation of assessment tools, treatment group curricula and descriptions, facility trauma policies, and restraint-reduction programs developed and/or in use at New York State Office of Mental Health Psychiatric Centres.

The Elizabeth Stone House: A Boston Women's Mental Health

Alternative

P.O. Box 59, Jamaica Plain, MA 02130
(617) 522-3417

Founded by former mental health consumers in 1974, the Elizabeth Stone House works with women dealing with mental health problems that are often linked to violence and trauma. It provides three residential programs, support groups and community advocacy programs. The organization has produced a handbook entitled, *The Elizabeth Stone House Handbook, Sheltering People in Emotional Distress* by Ann Beckart, Deborah Linnell and Katrina Pope. This resource is meant to assist people in establishing a residential mental health program for women and children.

Listening to High Utilizers of Mental Health Services: Recognizing, Responding to and Recovering from Trauma

Lyn Blackshaw, Andrea Levy and Janice Perciano, 1999
State of Oregon Mental Health and Developmental Disabilities Service
Division
2575 Bittern Street, NE, Salem, OR 97310
(503) 945-9700
www.omhs.mhd.hr.state.or.us

Although the research and recommendations in this report are not based on a gendered analysis of violence and trauma, it recommends a “map of safe options” model of treatment and support for survivors of severe childhood and adult trauma. It specifically follows up on a task force report that recommended the discontinuation of long-term hospitalization for self-harming consumers often with a diagnosis of borderline personality disorder, post-traumatic stress disorder, or dissociative identity disorder. The research is based on interviews with adult consumers, visits to mental health organizations and a review of clinical research and practice.

Safe, Secure and Street Smart: Empowering Women with Mental Illness to Achieve Greater Independence in the Community

Jessica Jonikas and Judith Cook, 1993
National Research and Training Centre on Psychiatric Disability
UIC National Research and Training Centre

Suite 900-104 South Michigan Avenue, Chicago, Illinois 60603
(312) 422-8180
www.psych.uic.edu/uicnrtc

A manual designed to help women with mental illness achieve independent community living through assistance in enhancing safety in their communities, workplaces, hospitals and rehabilitation programs.

Hope for Healing: Recovery and Empowerment for Women Consumers/Survivors with Abuse Histories

Alexandra Laris, Jessica Jonikas and Judith Cook, 2000
National Research and Training Centre on Psychiatric Disability
National Research and Training Centre
Suite 900-104 South Michigan Avenue, Chicago, Illinois 60603
(312) 422-8180
www.psych.uic.edu/uicnrtc

This curriculum manual is designed to meet the needs of women violence survivors who also have psychiatric diagnoses. Its primary purpose is to provide survivors with the skills needed to develop personal strengths and coping strategies.

D. ADDITIONAL RELATED BOOKS/REPORTS

The following materials are not all exclusively about violence and trauma but provide additional information about women's mental health care needs.

Hearing Voices: Mental Health Care for Women

Marina Morrow with Monika Chappell
The British Columbia Centre of Excellence for Women's Health, 1999.

Violence Against Women, Improving the Health Care Response: A Guide for Health Authorities, Health Care Managers, Providers and Planners

Marina Morrow and Colleen Varcoe
British Columbia Ministry of Health Services, Women's Health Bureau, 2000.

Having Our Say: Women Mental Health Consumers/Survivors

Identify Their Needs and Strengths

Jessica Jonikas, Edie Bamberger and Alexandra Laris
University of Illinois at Chicago, 1998.

Toward Gender-Sensitive Mental Health Services for Women Consumers

Winnipeg: Mental Health Branch: Community & Mental Health Services
Division Manitoba Health, 1996.

Women's Mental Health Services: A Public Health Perspective

Bruce Lubotsky Levin, Andrea Blanch and Ann Jennings (Eds.)
Thousand Oaks California: Sage, 1998.

Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions

Jane Davidson
New South Wales, Australia, 1997.

Cognitive-Behavioral Treatment of Borderline Personality Disorder

Marsha Linehan
Guilford Press, 1993.

The Link Between Childhood Trauma and Mental Illness: Effective Intervention for Mental Health Practitioners

Barbara Everett and Ruth Gallop
Sage Publications, 2000.

VIII

Endnotes

¹ These were the names of these health regions at the time of the research.

² For example, these terms are used to describe physical and sexual abuse in childhood, adult experiences of physical and sexual assault, and the experiences of people who have survived war, torture and other traumatic experiences.

³ For example, Beck and van der Kolk, 1987 and Craine et al., 1988 looked at adult women hospitalized for serious mental illness, and found rates of retrospective reported abuse of 34% to 54% respectively.

⁴ See the British Columbia Ministry of Health Services and Ministry Responsible for Seniors, Health Goals for British Columbia, Victoria: BC Ministry of Health Services and Ministry Responsible for Seniors, 1997, and British Columbia Women's Hospital and Health Centre Society, The Challenges Ahead for Women's Health, Vancouver: Consultation Working Group, 1995.

⁵ In the Vancouver/Richmond Health Region both violence against women and mental health have separately been identified as key priorities for health planning (Vancouver/Richmond Health Board, 2000).

⁶ In Canada, an average of two women per week were killed by their partners during 1990 (Canadian Advisory Council on the Status of Women, 1991).

⁷ It is interesting to note that the Diagnostic and Statistical Manual did not include the diagnosis of post-traumatic stress disorder (which is often applied to trauma survivors) until 1980.

⁸ The British Columbia Specialized Victim Assistance and Counselling Program, the British Columbia and Yukon Society of Transition Houses, and the then British Columbia Ministry of Health, the British Columbia Ministry of Attorney General, and the Ministry of Women's Equality, sponsored this symposium. Invitations went to transition houses, sexual assault centres, women's centres and specialized victim services

across British Columbia.

⁹ The 1998 BC Mental Health Plan identifies people with “serious mental illness” as those who have been diagnosed with either schizophrenia, major depression or bipolar disorder. The plan also acknowledges “that there are others for whom medical risk and impairment, regardless of diagnosis, determines their mental illness as serious” (British Columbia Mental Health Plan, 1998: 92).

¹⁰ See Appendix 1 for the full focus group protocol/questions.

¹¹ In this instance a focus group was not possible as the program was in the process of training new workers.

¹² This focus group and the interviews were chosen because at the time of the research the Health Sub-committee was working with the British Columbia Ministry of Health Services, Adult Mental Health on a pilot project to address violence against women.

¹³ For the full survey questions see Appendix 2.

¹⁴ Two recent examples include the Emergency Mental Health Educational Manual developed in 2000 by the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia, and the two-volume educational report developed in Australia and distributed in 2000 by Adult Mental Health Services entitled Management of Mental Health Disorders. Neither of these practice manuals adequately acknowledge the role that gender inequities may play in mental health.

¹⁵ Diagnoses are determined through psychological assessment and categorized according to the Diagnostic and Statistical Manual IV. Axis I diagnoses include schizophrenia, severe depression and mood disorders.

¹⁶ The nurses in this focus group had received training from the staff of British Columbia Women’s Hospital’s Violence Against Women in Relationships Program.

¹⁷ The British Columbia Schizophrenia Society, the Mood Disorders Association of British Columbia, the British Columbia Coalition of People with Disabilities, the Association for Awareness and Networking Around

Disordered Eating, the Canadian Mental Health Association – BC Division, the Anxiety Disorders Association of British Columbia, and the Mental Health Evaluation and Community Consultation Unit.

¹⁸ For example, one of the key agencies in Vancouver working with child sexual abuse survivors has had to close their waiting list for over a year.

¹⁹ At the time of the research, the regions included the Central Vancouver Health Region, Cariboo Health Region, Fraser Valley Health Region, North Shore Health Region, Central Vancouver Island Health Region and the East Kootenay Health Region.

²⁰ The Riverview initiative addresses both women and men with trauma histories.

²¹ This funding is a one-time initiative by the British Columbia Ministry of Health Services and is being coordinated and evaluated through the British Columbia Centre of Excellence for Women's Health.

²² M. Morrow & A. Pederson. *Mental Health Care for Women: A Tool to Assist Regional Mental Health Directors and Managers in British Columbia*. Victoria: Ministry of Health Services, 2001 (under review).

²³ M. Morrow & C. Varcoe. *Violence Against Women, Improving the Health Care Response: A Guide for Health Authorities, Health Care Managers, Providers and Planners*. Victoria: Women's Health Bureau, 2000.



Centre d'excellence
de la C-B pour la
santé des femmes

Vancouver, C.-B.
CANADA

Violence et traumatisme chez les femmes atteintes d'une maladie mentale grave

**pratiques actuelles de prestation
de services en Colombie-Britannique**

Ce rapport de recherche sur la santé des femmes est offert en français et sous des formes utilisables par les personnes handicapées. Pour plus de détails, veuillez communiquer avec le Centre d'excellence de la C.-B. pour la santé des femmes

ISSN 1481-7268



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