Building Bridges

INTEGRATED NEEDS, INTEGRATING SERVICES
Improving our response to women

Linking
SUBSTANCE USE
WOMAN ABUSE
MENTAL ILL HEALTH

BUILDING BRIDGES: LINKING WOMAN ABUSE, SUBSTANCE USE AND MENTAL ILL HEALTH

Prepared by Jill Cory, Louise Godard, Alexxa Abi-Jaoude & Lauren Wallace
Woman Abuse Response Program
BC Women's Hospital and Health Centre
April 2010

This summary document provides background information on the Building Bridges initiative and presents the preliminary findings from the provincial consultation with service providers and women impacted by abuse and mental ill health and/or substance use. The project is lead by the Woman Abuse Response Program, a provincial program of BC Women's Hospital and Health Centre. These findings will form the basis of discussion and planning for the upcoming Building Bridges Symposium and Stakeholder meeting. A final report will be released in the Fall 2010, presenting a framework for enhanced service provision, programming and policy to support women impacted by the overlapping concerns of woman abuse and substance use and/or mental ill health.

> **"If you get the help that you need, you're more open or willing or more optimistic to go and seek help again."**
>
> *– Woman Abuse Survivor*

This project is co-funded by the BC Women's Woman Abuse Response Program and the Vancouver Foundation.

vancouver foundation

Woman Abuse Response Program – BC Women's Hospital and Health Centre, Room AB306, 4500 Oak Street, Vancouver, BC V6H 3N1
For more information: http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm

CONSULTATION HIGHLIGHTS

As a provincial leader in woman abuse and women's health, the Woman Abuse Response Program (WARP) at BC Women's Hospital and Health Centre identified the need to further our knowledge and improve the response to the intersecting issues of abuse and substance use and/or mental ill health in the lives of girls and women in BC.

To achieve this, WARP engaged in preliminary provincewide consultations and educational forums with over 1000 community and health care stakeholders beginning in 2006. This lead to the initiative ***Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health***.

In 2008, with funding from BC Women's Hospital and Health Centre, Vancouver Foundation and MOMentum, the Woman Abuse Response Program advanced the work of the Building Bridges initiative by conducting a province-wide consultation. Since October of 2008, WARP has conducted standardized, cross-sectoral consultations and individual interviews with 460 service providers and policy leaders primarily from the anti-violence, addictions, mental health, and health care sectors, with participation from some community, child protection and social service organizations. Consultation participants represented 82 communities in BC. As well, the team conducted 13 focus groups across BC (n=100) among women who had experiences of abuse and substance use and/or mental health issues.

The primary purpose of this consultation was to systematically gather information about whether services in BC were meeting the needs of women who have experiences of abuse and substance use and/or mental health issues. Participants shared their insights about the barriers and gaps within current service models; challenges to increasing accessibility and inclusivity; and strategies, promising practices and recommendations for improving policy, programming and practice. The findings will be used to develop a provincial framework that will inform policy, funding and program planning for services that support women impacted by these three issues.

UNDERSTANDING THE LINKS BETWEEN WOMAN ABUSE AND SUBSTANCE USE AND/OR MENTAL ILL HEALTH

There is evidence that many mental health problems post-date experiences of abuse. Therefore, "mental health issues should be treated as effects of abuse and not as mental disorders per se." [1]

The association between woman abuse, substance use and mental health issues has been well documented across demographic groups and diverse treatment settings.[2,3] Strong evidence shows that women's experiences of abuse precede their substance use and/or mental health issues.[4, 5, 6] At the same time, there is evidence that substance use and/or mental health issues can create a vulnerability to abuse and that the pre-existence of these conditions may exacerbate the effects of abuse.[4, 7]

Women in the Building Bridges focus groups describe the complexity of the connection.

> **"The abuse part… I think sometimes the abuse comes first, for some of us, and then I think the abuse continues because of the drugs and alcohol. It changes your personality… especially if you have mental health. Mental health, get some crack in there and some meth in there… you're a different person."**
>
> *— Kathy*

> **"We use the drugs to try and mask the abuse. And once you stop using them flashbacks come. It's just a constant. We just self-medicate. Trying to push those memories out."**
>
> *— Christine*

> **"It's totally inter-related. Because abuse in relationships, depression, guilt, and then anxiety reducers, whether it's ups or downs in your emotional state or whether it's drugs or whatever it is I need today so I can forget about my pain or feel pretty or whatever. So, it's all connected."**
>
> *— Carrie*

ANTI-VIOLENCE, ADDICTIONS AND MENTAL HEALTH SERVICES ARE SERVING WOMEN WITH OVERLAPPING EXPERIENCES

Anti-violence, addictions and mental health services are clearly serving women with overlapping experiences of abuse, substance use and mental health issues.

For example, within transition houses, it has been documented that over half of women experience major depression[8] and over one third have diagnoses of post-traumatic stress disorder.[9] The prevalence of substance use disorders among women in these shelters has been estimated to range from 33% to 86%.[5]

Within substance use treatment, two out of five women also have a major mental health disorder,[10] two out of three have a history of abuse,[11] and half are in a currently abusive relationship.[12] Alcohol dependency is 15 times more prevalent among women impacted by abuse than the general public.[13]

Within mental health services, among inpatient populations, it was approximated that as much as 83% of women had been exposed to severe physical or sexual abuse as a child or adult.[14] One study showed that 70% of women in psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse.[15]

An Ontario-based study revealed that regardless of which sector- anti-violence, addictions or mental health- women facing these three issues were in contact with, each had a similar history of experiences of abuse, substance use and mental health issues. [6] These findings indicate that the types of issues that women are facing are quite similar, regardless of which sector women engage with,[6] and that providers within each of these sectors will often serve the same women.

CHALLENGES ACROSS ADDICTIONS, MENTAL HEALTH AND ANTI-VIOLENCE SERVICES

There is strong international evidence to suggest that women-centred, integrated services are more effective than 'siloed' services for working with this population of women.[16, 17, 5] As part of the Building Bridges consultation, we conducted follow-up interviews with 19 service providers across BC to highlight approaches that reflect women-centred, integrated, collaborative principles.

Overall, however, our findings suggest that few agencies are equipped to provide the range of services needed by abuse survivors who also experience substance use and/or mental ill health as a result of woman abuse. Practitioners and women impacted by these issues observed that the lack of women-specific, integrated and collaborative service models across sectors, along with inadequate training for staff, are the norm. These limitations are having a negative impact on the safety and health of women.

> **"We as violence sector workers know that these issues have been "individualized" for so many years when in fact they have been intertwined and it is important to have all service providers understand the links for women's safety."**
>
> *— service provider*

The vast majority of participants in the consultation agreed that there were myriad challenges in providing compassionate, inclusive, integrated services to this population of women. They raised concerns about whether current service models are able to address the significant number of women who seek services.

> **"It's difficult to integrate services when the different sectors or service providers have different opinions on what the women should do instead of being women centred."**
>
> *— service provider*

GAPS AND BARRIERS

Findings from the Building Bridges Consultations consistently show that women face multiple, serious gaps and barriers in trying to access services. In instances when women do gain access, often the support they receive is not reflective of their needs.

Below are a number of key barriers identified in the consultation:

Mandates that ignore the impact of woman abuse:

"Their mandate was to make me employable. I never dealt with the abuse issues… They taught me things like budgeting and parenting but I never dealt with those issues to be able to parent or be in a work environment because of the abuse."

— Charlene

"I wasn't allowed into the transition house because I had a mental health diagnosis. They didn't understand that it was because of the abuse."

— Dot

Compartmentalizing issues:

"Mental health issues are construed as separate from abuse – now that's crazy!"

— service provider

Competing and Contradictory Services:

"Substance use counseling is sometimes in conflict with mental health counseling, and neither support women's safety and other impacts of abuse."

— service provider

"We're forced to choose one issue to deal with at a time."

— Chelsea

Not Recognizing the Impacts of Abuse:

"Going to my doctor, I used to break down and cry in his office and he'd say, 'you're depressed'. 'No I'm just sad. I'm just going through a really sad time'. He said, 'there's a name for that. It's depression'. Finally he convinced me I should go on an antidepressant. Like that was going to stop me from being beat up."

— Gillian

Lack of Integration:

"These three things are impacting women's lives at the same time and make it difficult to access services because of 'silos' and turf issues."

— service provider

"It doesn't work to address one issue without the other. They can't be separated."

— Carolina

"When women present with all three, it prevents them from getting services because no one wants to touch these women."

— service provider

Service outcomes:

"This way we look like we're really successful in our interventions. Just leave out the hard-to-treat."

— service provider

"Women feel trapped and don't know where to turn to and end up in a cycle which leads to addiction as an escape and possible mental health issues through continuous trauma."

— service provider

Unintentional Harms

Despite the intention of these sectors to enhance women's health and safety, a growing body of research has revealed that these services can unintentionally cause harm.[18, 19, 20, 21, 22] Dr. Carole Warshaw emphasizes the potential for harm, stating

> it is important to recognize that revictimization can take place in clinical interactions and that the distortion of meaning and denial of experience that are used as tactics of psychological control in abusive relationships can be inadvertently repeated in health care encounters if the clinician is unable to recognize and validate the traumatic context in which a person's symptoms develop and are perpetuated.[21]

"Women are punished by the systems that are designed to help them: MCFD, social work, police, housing, healthcare and "helping field" women's services. The system is harmful."

— service provider

When women's substance use and mental ill health are not identified as rooted in abuse, the impacts of abuse may be misdiagnosed as mental health or addiction problems. Women's safety may be compromised by inappropriate interventions when her safety is not paramount.

> **"[This] puts women in harm by minimizing the abuse - as symptoms such as substance abuse, trauma, depression, anxiety."**
>
> *— service provider*

Conversely, if substance use and mental health issues are not acknowledged as impacts of abuse, women seeking safety and support from anti-violence services may not receive appropriate services or be eligible to access support.

> **"We're not able to help the most vulnerable because of our mandate. We can't serve them if their primary issue is mental health or addictions."**
>
> *— service provider.*

Facing Compounding Social Inequities

Participants agreed that many women face additional inequities such as lack of safe and affordable housing, financial security, childcare/support and transportation. Limited or lack of services for women such as Aboriginal women, immigrant and refugee women, lesbian and trans-gendered women, rural women and women who are mothering further marginalizes these communities of women.

Housing:

> **"For one, nobody can get on with their lives being homeless. Nobody. If you're on totally survival mode, you can't get on with your life until you've got your basic needs of shelter and food met, you can't, and you can't. So I really hope that the government is going to provide more housing."**
>
> *— Mary*

Poverty:

> **"It's demeaning. It's utter, absolute, you feel lower than a snake in a wagon race. Of course you sink into a deeper depression because of it. There's no way your income will ever equal a man's income..."**
>
> *— Jackie*

THE NEED FOR VIOLENCE-INFORMED PRACTICE AND POLICY (VIPP)

A health-care response that adequately addresses woman abuse should focus on the underlying safety concerns of women and the physical and mental health care impacts resulting from the abuse. Since many women choose not to disclose abuse when asked routine screening questions, it is vital to develop an approach that can address the safety and health issues of women impacted by abuse, without retraumatizing women or requiring disclosure. In order to also take into account on-going experiences of abuse/violence and to attend to women's current safety needs, WARP has developed the concept of 'Violence-informed Practice and Policy (VIPP)'.

A violence-informed approach recognizes that gender-based violence is pervasive in the lives of girls and women around the world and that practitioners are serving a high percentage of women impacted by abuse, whether they are aware of it or not. Recent reports from the World Health Organization indicate that 29%-62% of women who have had a partner have also experienced physical or sexual violence, or both, in their relationships.[23] Since so many girls and women are impacted by abuse,

> we need to develop a health care structure and a practice that starts from the premise that every woman could be experiencing abuse, but that not every woman is experiencing abuse. It is incumbent upon the system to uncover and reduce the potential risks women encounter in health systems and increase the protective measures to ensure women's safety to the greatest possible degree rather than expecting women to disclose abuse simply because we have asked them routine screening questions.[24]

Violence-Informed Practice and Policy is similar to 'trauma-informed care' in that it recognizes the impact of women's previous experiences of violence and the potential for retraumatizing women seeking care. However, effective trauma interventions are not necessarily safe for women who are currently with, or still unsafe from an abusive partner. Trauma interventions presume that women have experienced traumatic events that are behind them, have autonomy from their perpetrators/events and can build on women's strengths through strategies such as self-regulation, self-soothing,

limit setting and assertiveness, and communication. These interventions would not be safe (or even possible) if her abusive partner was still in the picture and any attempt to set boundaries or act independently would increase the risks to her safety. A VIPP approach also recognizes the significant ongoing impact that an abusive partner has on a woman's safety and health, and that his presence poses a serious risk for a woman who is trying to make changes in her life.

Many health conditions, including substance use and mental health concerns, result from a woman's experiences of abuse. Employing a violence- and gender- informed approach and integrating this knowledge into all aspects of service delivery will make certain that service providers pay attention to the nature and quality of the relationship. With primary consideration for the lived context in which mental health and substance use issues arise, the provider ensures that their first concern is directed towards women's safety and health.

Dr. Carole Warshaw observes that the crucial aspect is having the health sector realize that "for someone who has been abused... experiencing equality, safety, mutuality, and empowerment are essential to the process of healing and reclaiming one's sense of self and place in the world." [21]

FUTURE DIRECTIONS

Practitioners and women highlighted the critical need for direction and action to expand service mandates, improve staff capacity and develop effective services that focus on women's safety and health. Building Bridges participants envision that improving service delivery by making these connections will lead to the following key outcomes:

Integrated services and service delivery

Providing training on the intersection of these issues and promising practices will improve the capacity and ability of services across the sectors to respond to the intersecting issues. This will benefit women as well as potentially legitimize the work of all three sectors.

Service models will reflect women's realities

Policy and programming will support trained service providers to work with the diverse women accessing their services. This will strengthen providers' ability to support women, including the more marginalized and vulnerable women. Employing policy and programming that reflects women's reality also has the potential to reduce frustration and burnout among service providers.

Increased collaboration, coordination and partnerships

Despite the challenges and differences, there are many similarities across the sectors that can provide opportunities for cross-sectoral work and collaboration. This approach will increase the relevance and effectiveness of service provision and improve opportunities for women's health and safety.

CONCLUSION

Building Bridges aims to draw attention to the existing research; practitioner, organizational and community perspectives; and promising practices to effectively and comprehensively respond to the intersection of violence, substance use and mental ill health. It aims to stimulate discussion and collaboration among practitioners around how to identify and promote practice and policies that are relevant, effective and respond to women's health and safety needs. Change of this magnitude requires provincial cross sector engagement, thinking, networking and action from a broad range of stakeholders, which are the cornerstones of the Building Bridges initiative.

NEXT STEPS

Building Bridges Symposium and Stakeholder Meeting, May 31, 2010.

ENDNOTES

1. Stark E, Flitcraft A. (1991).Spouse abuse, In Rosenburg M, Fenley M, eds, Violence in America: A Public Health Approach. New York, Oxford University Press.

2. Huntington, N., Moses, D.J., Veysey, B.M. (2005). Developing and implementing a comprehensive approach to serving women with co-occurring disorders and histories of trauma. Journal of Community Psychology, 33(4), 395- 410

3. Gatz, M., Brounstein, P., Taylor, J. (2005). Serving the needs of women with co-occurring disorders and a history of trauma: special issue introduction. Journal of Community Psychology, 33(4), 373-378

4. Gatz, M., Russell, L.A., Grady, J., Kram-Fernansez, D., Clark, C., Marshall, B. (2005). Women's recollections of victimization, psychological problems, and substance use. Journal of Community Psychology, 33(4), 479-493

5. Humphreys, C., Thiara, R.K., Regan, L. (2005). Domestic violence and substance use: overlapping issues in separate services? Retrieved January 30, 2010 from http://www2.warwick.ac.uk/fac/soc/shss/swell/research/final_report.pdf

6. Purdon, C. (2008). No wrong door. Creating a collaborative rural response for woman abuse, mental health and addiction issues. Retrieved March 3, 2010 from http://www.endabusenow.ca/files/Final%20Report%20No%20Wrong%20Door%20.pdf

7. Testa, M., Livingston, J.A., Leonard, K.E. (2003). Women's substance use and experiences of intimate partner violence: a longitudinal investigation among a community sample. Addictive Behaviour, 28, 1649-1664

8. Helfrich, C.A., Fujiura, G.T., Rutkowski-Kmitta, V. (2008). Mental health disorders and functioning of women in domestic violence shelters. Journal of Interpersonal Violence, 23(4), 437- 453

9. Street, A.E. & Arias, I. (2001). Psychological abuse and post-traumatic stress disorder in battered women: Examining the role of shame and guilt. Violence and Victims, 16(1), 65-78

10. Havassy, B.E., Alvidrez, J., Owen, K.K. (2004). Comparison of patients with comorbid psychiatric and substance use disorders: Implications for treatment and service delivery. American Journal of Psychiatry, 161(1), 139-145

11. Miller, B.A., Downs, W.R., Testa, M. (1993). Interrelationships between victimization experiences and women's alcohol use. Journal of Studies on Alcohol, 11, 109-117 CA.

12. Swan, S. Farber, S., Campbell, D. (2001). Violence in the lives of women in substance use treatment: service and policy implications. Retrieved January 17, 2010 from http://www.womensconsortium.org/pdf/swan001025.pdf

13. Logan, T., Walker, R., Cole, J., & Leukefeld, C. (2002). Victimization and substance use among women: contributing factors, interventions and implications. Review of General Psychology, 6 (4): 325-397

14. Firsten, T. (1991). Violence in the lives of women on psychiatric wards. Canadian Women's Studies, 11(4), 45-48

15. Phillips, Kelley (2000) "Sociogeopolitical issues" in Steiner, Meir, Yonkers, Kimberley and Eriksson, Elias (ed.) (2000) Mood Disorders in Women, London: Martin Dunitz, Ltd.

16. Amaro, H., Dia, J., Arevalo, S., Acevedo, A., Matsumoto, A., Nieves, R. Prado, G. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance use treatment. Journal of Urban Health, 84(4), 508-519

17. Morrissey, J.P., Jackson, E.W., Ellis, A.R., Amaro, H., Brown, V.B., Najavits, L.M. (2005). Twelve-month outcomes for trauma-informed interventions for women with co-occurring disorders. Psychiatric Services, 56(10), 1213-122

18. Frueh, C.B., Dalton, M.E., Johnson, M.R., Hiers, T.G., Gold, P.B., Magruder, K.M., Santos, A.B. (2000). Trauma within the psychiatric setting: conceptual framework, research directions, and policy implications. Administration and Policy on Mental Health, 28(2), 147-154

19. Markoff, L.S., Glover Reed, B., Fallot, R.D., Elliot, D.E., Bjelajac, P. (2005). Implementing trauma-informed alcohol and other drug and mental health services for women: Lessons learned in a multisite demonstration project. American Journal of Orthopsychiatry, 75(4), 525-538

20. Elliot, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., Glover Reed, B. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. Journal of Community Psychology, 33(4), 461-477

21. Warshaw, C. (1997). Intimate partner abuse: developing a framework for change in medical education. Academic Medicine, 72 (Supplement): p. S26-S37

22. Fallot, R.D. & Harris, M. (2001). Trauma-informed systems of care: an update. Retrieved January 30, 2010 from http://mentalhealth.samhsa.gov/nctic/newsletter_10-2007.asp#update

23. World Health Organization (2005). Multi-country Study on Women's Health and Domestic Violence against Women. Geneva: WHO Press.

24. Cory, J. & Dechief, L. (2007). SHE Framework: Safety and Health Enhancement for Women Experiencing Abuse. A toolkit for health care providers and planners. BC Women's Hospital and Health Care Centre, BC Institute Against Family Violence: Vancouver, BC. downloadable from: http://www.whrn.ca/documents/aaSHEFramework.pdf

Prepared by Jill Cory, Louise Godard, Alexxa Abi-Jaoude & Lauren Wallace
Woman Abuse Response Program April 2010
BC Women's Hospital and Health Centre

This project is co-funded by the BC Women's Woman Abuse Response Program and the Vancouver Foundation.

vancouver foundation

Woman Abuse Response Program – BC Women's Hospital and Health Centre, Room AB306, 4500 Oak Street, Vancouver, BC V6H 3N1
For more information: http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm