MAKING CONNECTIONS

When Domestic Violence, Mental Health and Substance Use Problems Co-Occur

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Be sure to check out the online version of this training at **www.DVeducation.ca**

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PREAMBLE

When we set out to develop a curriculum on the intersections of domestic violence with mental health and substance use problems, we knew we were taking on a huge task. We envisioned a curriculum grounded in research literature, informed by the expertise of those working in the field, and reflective of the wisdom of those with lived experienced of these problems. We envisioned a substantive discussion of these issues but in a format that would be both useful and practical. To that end we developed a set of concrete competencies to guide the curriculum content. The competencies reflect the specific knowledge and abilities addressed in the curriculum. To support and augment the content in this manual we have also prepared an interactive online version found at **www.DVeducation.ca**.

We could not have done this work alone. We began by inviting shelter workers, violence against women (VAW), community mental health and addiction counsellors; and women with lived experience of these problems, to share with us their experiences of providing and seeking help, the challenges of day-to-day practice – as well as ways for overcoming those challenges. We asked about stigma, organizational policies, building networks and collaboration. We searched out helpful models, resources and tools from across the province, the country and beyond. Accompanying us on this journey was a dedicated advisory committee and a host of expert contributors and reviewers.

We hope this curriculum and training will inspire innovative practices and new models of care. We believe it will be a helpful introduction to these complex problems. But these are complex problems and it must be acknowledged that some women face greater structural challenges and stigma than others. We have tried to be mindful of the many ways in which social location affects women's experiences – however it was beyond the scope of this project to explore the particular struggles of finding accessible, affordable, culturally appropriate services in one's own language, and these issues have not been explored here in the depth they deserve.

INTRODUCTION

The abuse women experience by their intimate partners, here called domestic violence or DV but also known as woman abuse or intimate partner violence, has been a focus of research, policy development and changes to practice for several decades. More recent, however, is the recognition that DV is often bound up with other complex and co-occurring issues, in particular mental health and substance use problems. Less is known about these interconnections and how to support the women who experience them. The research, policies, and practices regarding the intersection of these co-occurring problems are all at an initial stage and it has been difficult to find evidence-based training materials (materials based on peer-reviewed research) to help those wanting to learn more.

In December 2009, with funding from the province of Ontario, we set out to develop an educational resource to begin to address this knowledge gap. In doing so, we were committed to maintaining a number of key principles and values.

The first principle is safety; her safety, the safety of other women and their children, and your safety too. The thread of safety (enhancing, managing and maintaining safety) will run throughout this training. Sometimes the issue of safety will be clear and in the foreground, at other times it will be less visible.

The second principle we've followed is to hold the woman at the centre of all of our work; she is the expert and needs respect on her journey. From this principle emerges the value of practicing woman-centred care. Woman-centred care recognizes the ways in which she is unique and uniquely impacted by her gender, sexual orientation, roles and responsibilities, income, class, race, culture, immigration status and ability. It also means that we recognize and value her strengths and acknowledge her resilience.

The third principle is that each woman is more than the label(s) or diagnosis(es) that she carries. We need to ask, "what has happened to her?" instead of "what is wrong with her?" As well, each woman is a unique individual and we need to remember to see her and treat her as a whole human being. The same holds true for each of us. We are more than just our role or function or job and we too have both strengths and limitations that we need to acknowledge and respect.

THE METHODS WE USED

We began with a systematic review of the academic literature to learn about existing curricula, best practices and treatment modalities for women experiencing DV and co-occurring mental health or substance use problems. A systematic review is one in which the published academic literature is searched using a specific search engine, key words and other clearly defined criteria. In this case we were looking for published research on the co-occurrence of DV with mental health and substance use, and more specifically, on training and education regarding these problems. In a second search we specifically looked for information on practices within the VAW shelter system for supporting women who experience these complex and intersecting problems. There was very little published literature to draw upon. (Search terms and strategies appear in Appendix 3-1). To expand our search, we also reviewed the gray literature (literature not published in academic journals) to gather more information. In addition, we completed an environmental scan of Ontario's community colleges and universities to learn more about what information about these co-occurring problems is being taught in programs for social service workers, addiction counsellors, and social workers.

At the same time, we established a 15-person provincial advisory committee with representatives from each of the three sectors as well as women with lived experience of these problems.

Through the fall of 2010 we held 10 regional round tables to learn more about day-to-day practices in working with women who experience these co-occurring problems. The round table sites were chosen on the basis of geographic location (urban, rural, near northern), cross-sectoral representation and inclusion of survivor participants. As these were organized with the help of local Domestic Violence Community Coordinating Committees, many of the discussions also included representatives from the justice sector including police and victim witness assistance programs, child welfare representatives, as well as those who work with perpetrators. (See map on page 5 for locations of round tables). Each of these discussions was analyzed for common issues/themes and the results were shared with the advisory committee.

In the fall of 2011, three additional round tables with frontline shelter workers and one with executive members of Ontario Association of Interval and Transition Houses (OAITH) were held via teleconference to learn more about the specific challenges facing those working in VAW shelters.

We also consulted with experts outside of the province to learn about the ways other communities are addressing these challenges.

In total more than 300 individuals shared their knowledge, experience and thoughtful reflections on these issues and possible solutions. We heard a lot about the challenges of working with women who

experience co-occurring problems, we learned about a range of service delivery models and we repeatedly heard about the need for more education and training. Examples of what was shared through these discussions appear as quotes throughout this document.

WHAT YOU'LL FIND IN THIS RESOURCE

We've prepared this resource package, website and the accompanying workshop to provide background information and concrete tools for working with women who experience complex and interconnecting problems. But we begin with a historical framing of these problems because it is important to understand where we have come from (as VAW, mental health, or substance use counsellors) so that we can learn together how best to move forward.

In section one you'll find the different historical frameworks, philosophies and approaches that have evolved in responding to women who have experienced abuse, mental health or substance use problems. The objective is to appreciate the strengths and limitations of each of these approaches.

Section two is an introduction to each of the subject areas, and answers the questions "What is domestic violence? What is mental health or mental illness? What is substance use?" In addition, common indicators are included, as well as information about the impact of each of these problems on children and family functioning. The objective is to create a common understanding of these problems, to provide some information about how many women experience these problems, and to share some indicators to help you recognize a problem.

Does DV lead to mental health or substance use problems? Do substance use issues or mental health problems lead to violence? Section three explores why and how these problems are connected.

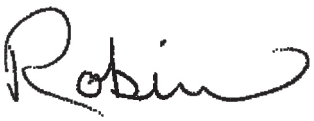
In section four you'll find some practical tools you may need in your day-to-day practice to support women who experience these co-occurring problems.

Section five focuses on collaboration and provides concrete suggestions on how to develop useful collaborations and networks across organizations, with the goal of providing better referrals and support to the women with whom you work.

Section six is about you. It will tell you how to increase compassion satisfaction, how to recognize compassion fatigue and burnout, and how to become re-energized and take care of your most valuable resource: you.

We've called this project *Making Connections*, a name that is emblematic of the connections we've made with our collaborators, with the many dedicated workers across the province, with the women who have shared their stories, as well as the complex connections linking domestic violence, mental health and substance use. As you go through this manual, website and the accompanying workshop, we hope you too will make new connections, that you find this an opportunity to share your knowledge and skills with colleagues in other sectors, and that together we can all better support the women who experience these co-occurring problems. These are not simple issues. Helping women who experience these problems is not a simple task. No one of us can do it all but together we might just do it better.

Robin Mason



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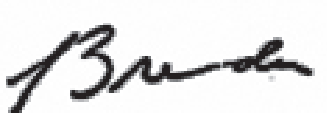

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EDUCATIONAL COMPETENCIES FOR WORKING WITH WOMEN WHO EXPERIENCE CO-OCCURING DV, MENTAL HEALTH AND/OR SUBSTANCE USE PROBLEMS

I. Have a basic understanding of each of the following: Domestic Violence (DV), mental health and substance use

II. Understand the relationships among DV, mental health, & substance use

a. Recognize the potential consequences of childhood trauma on women and their partners

b. Understand the multiple effects of DV on women (e.g. mental and physical health, financial status, parenting, substance use and other social determinants of health)

c. Understand the ways substances may be used by women who experience or have experienced DV

III. Recognize that different professional bodies draw upon their own historical beliefs, frameworks, and practices to understand and provide care

a. Be familiar with the languages used in each of these frameworks

b. Acknowledge the strengths and limitations of these frameworks including how they inform treatment or care

IV. Know what is required to keep her (and her children) safe and healthy: immediately, short-term, long-term

Assess for:

a. Risk for future DV victimization including femicide, or suicidality

b. Risk for perpetration of DV, including homicide/femicide, and suicide

c. Substance use and withdrawal

d. Co-occurring issues of DV, mental health and substance use

e. Involvement with legal system

f. Child protection risks

Manage:

g. Crises

h. Interventions including working with her to determine and set priorities

i. Referrals

Complete:

j. Safety plan(s) as appropriate

k. Complete child protection report as required

V. Identify and know how to access local community, regional and provincial resources for women who experience DV, mental health and substance use problems

a. Know how to effectively work together

b. Understand different roles, responsibilities and frameworks used by practitioners she may encounter when accessing other services

c. Work to improve networks of care for those who experience co-occurring problems

VI. Understand the ways in which DV, mental health and/or substance use may affect relationships including those with intimate partners, parent/child dynamics, family & community and therapeutic/counselling relationship

VII. Demonstrate appropriate verbal and nonverbal communication skills

VIII. Recognize the pros, cons and potential unintended consequences of disclosure (of DV, mental health and substance use), documentation, and treatment for women

IX. Understand how other social determinants (e.g. race, ethnicity, religion, disability, sexual orientation, citizenship status, age, geographic location, etc.) may interact with DV, mental health and substance use

X. Engage in reflective practice

a. Acknowledge your own values, attitudes, beliefs and experiences

b. Understand vicarious trauma/compassion fatigue/secondary trauma and practitioner burnout, be mindful of how these impact your practice and practice healthy self-care

c. Commit to continuous learning in all three sectors

CURRICULUM COMPETENCIES

Section	Competencies	Content Focus
Preamble		• Beliefs, values, principles • Method
Section 1: Frameworks, Philosophies and Practices	**III.** Recognize that different professional bodies draw upon their own historical beliefs, frameworks, and practices to understand and provide care **III.** b. Acknowledge the strengths and limitations of these frameworks including how they inform treatment or care **IX.** Understand how other social determinants (e.g. race, ethnicity, religion, disability, sexual orientation, citizenship status, age, geographic location, etc.) may interact with DV, mental health and substance use **X.** Engage in reflective practice **X.** a. Acknowledge your own values, attitudes, beliefs and experiences	Evolution of different frameworks over time and highlight specific issues for consideration regarding each framework **Legal/Judicial: Adversarial Orientation** • DV; Child and Family Services Act; Controlled Substances Act; Mental Health Act • Perpetrators under court order and confidentiality • when a court order exists • Children at risk – duty to report **Medical: Institutional** (hospitals/acute care; psychiatrists) **and Community Systems** (community health centres; holistic; less hierarchy than institutions; focus on social determinants of health) • Mental health models of service delivery o medical model: diagnosis/labels o psycho-social o "recovery" • Substance use models of service delivery o abstinence o harm reduction o self help (AA; NA) **Social Services** • Housing • VAW services **Societal** • Social and cultural factors (use of drugs; understanding of mental health/substance use and domestic violence) • Impact of social determinants of health factors: poverty; housing; class; religion; country of origin,etc. • Feminist – resiliency approach/anti-oppression o suspicion of medical/legal frameworks in some segments **Grassroots/Advocacy:** recognition that these frameworks exist like groups such as AA, NA, etc. but do not focus on philosophical underpinnings; relate to self-help model of service delivery • Emphasize that there are limitations to what providers can offer; limitations based on their organization's mandate, and their roles and responsibilities within the organization, and to a lesser extent the framework governing the sector, particularly useful when either first meeting a client (where she has come from) or when making a referral.
Section 2: DV, Mental Health and Substance Use	**I.** Have a basic understanding of each of the following: Domestic Violence (DV), mental health and substance use **III.** a. Be familiar with the languages used in each of these frameworks	**Introduction to DV** • Define DV and identify different forms of abuse o Power & Control wheel o Reference to different Power & Control wheels • Prevalence of DV – statistical data • Why is DV a health issue? • Evidence to support **Introduction to Women & Mental Health** • Prevalence of mental health issues in women • Relationship between DV and mental health **Introduction to Women & Substance Use** • Prevalence of substance use in women • Relationship between DV and substance use **Intersection between DV, Mental Health and Substance Use** • DV, mental health and substance use • Social determinants of health and relationship to DV; mental health and substance use

Section	Competencies	Content Focus
Section 3: The Complexities of Co-occurring Problems	**II.** Understand the relationships among DV, mental health and substance use **II**. a. Recognize the potential consequences of childhood trauma on women and their partners **II.** b. Understand the multiple effects of DV on women (e.g. mental and physical health, financial status, parenting, substance use and other social determinants of health) **II.** c. Understand the ways substances may be used by women who experience or have experienced DV **VI.** Understand the ways in which DV, mental health and/or substance use may affect relationships including those with intimate partners, parent/child dynamics, family & community and therapeutic/counselling relationship	• List categories of drugs used by women (and perpetrators) and intersection of effects, dependency control, inhibition and access to particular drugs – distinctions between using one or more substances; both non-prescription and prescription drugs • Mental health disorders/conditions often connected to trauma and intimate partner violence and different forms of abuse • Forms of abuse, power & control wheel • Tactics of abuse • Life span abuse, trauma • Indicators of abuse – children, women and perpetrator • Effects on children • Challenges when woman presenting with DV, mental health and/or substance use depending on which type of service and/or professional's framework/understanding of care (e.g. VAW worker presented with a woman who is also experiencing mental health or substance use issues – impact of individual & organizational service delivery practice – policies denying access to service if using substances for example)
Section 4: But What Do I Do?	**IV.** Know what is required to keep her (and her children) safe and healthy: immediately, short-term, long-term **Assess for:** **IV.** a. Risk for future DV victimization including femicide, or suicidality **IV.** b. Risk for perpetration of DV, including homicide/femicide, and suicide **IV.** c. Substance use and withdrawal, **IV.** d. Co-occurring issues of DV, mental health and substance use **IV.** e. Involvement with legal system **IV.** f. Child protection risks **Manage:** **IV.** g. Crises **IV.** h. Interventions including working with her to determine and set priorities **IV.** i. Referrals **Complete:** **IV.** j. Safety plan(s) as appropriate **IV.** k. Complete child protection report as required **VII.** Demonstrate appropriate verbal and nonverbal communication skills **VIII.** Recognize the pros, cons and potential unintended consequences of disclosure (of DV, mental health and substance use), documentation, and treatment for women	• Principles for effective intervention when women experiencing mental health or substance use issues and when there is disclosure or indicators of DV • Assessing need and providing appropriate linkages and referrals to supports and services • Assessing risk for personal safety for women (short term/long term) • Safety planning and tools regarding DV, mental health and substance use for women and children • Intervention for children at risk • Individual/systemic barriers impacting effective intervention • Different practice patterns and service delivery models depending on framework reinforcing strengths and limitations • Where to make referrals • Involvement with legal system • Crisis management • Pros, cons and potential unintended consequences of disclosure (of DV, mental health, substance use), documentation, and treatment for women
Section 5: Collaborating Across Disciplines, Sectors and Locations	**V.** Identify and know how to access local community, regional and provincial resources for women who experience DV, mental health and substance use problems **V.** a. Know how to effectively work together **V.** b. Understand different roles, responsibilities and frameworks used by practitioners she may encounter when accessing other services **V.** c. Work to improve networks of care for those who experience co-occurring problems **X.** a. Acknowledge your own values, attitudes, beliefs and experiences	• Systems/services and their roles • Policies and practices • Knowing your community (eg. what drugs are most readily available in your community) • Learning about services that are available • Identifying collaborative efforts that work and elements that promote successful collaboration • How to make personal contacts • Collaborating, networking – developing collective understanding of the problems • Mapping your community exercise

Section	Competencies	Content Focus
Section 6: Self Care and Compassion Fatigue	**V.** a. Know how to effectively work together **X.** Engage in reflective practice **X.** a. Acknowledge your own values, attitudes, beliefs and experiences **X.** b. Understand vicarious trauma/compassion fatigue/secondary trauma and practitioner burnout, be mindful of how these impact your practice and practice healthy self-care **X.** c. Commit to continuous learning in all three sectors	• Challenges of working with women who are experiencing DV, mental health and substance use • Vicarious trauma, compassion fatigue, secondary trauma, burnout • Self-assessment tool • Identification of individual, organizational and systemic practices that can minimize and manage vicarious trauma and compassion fatigue • Resources in community for self care, especially if experiencing compassion fatigue, vicarious trauma, burnout, PTSD • Importance of identifying personal goal to support continuous learning in all three sectors

SECTION ONE:
FRAMEWORKS, PHILOSOPHIES AND PRACTICES

This is where we always come back to theoretical frameworks and paradigms. Are there some theoretical perspectives or frameworks or ways of labeling these issues that are more helpful? … are we doing more harm with some of these labels and internalized beliefs?
(ROUND TABLE PARTICIPANT, KINGSTON, ON)

…I would implore all of us, in all of our sectors, to see the ways that the 'sectorization' or 'disciplination' of our tools, our lenses, our institutions, our frameworks gets in the way… just as much as we learn about what to see, if we can learn about what we are not seeing, it will serve us all. …use the wisdom and knowledge from all of these traditions but don't put people in boxes.
(ROUND TABLE PARTICIPANT, TORONTO, ON)

Through our conversations with more than 300 individuals working in the violence against women, community mental health, and substance use/addictions sectors, we have come to recognize the challenges inherent in transdisciplinary, cross-sectoral dialogue. It is clear that each sector has developed out of a particular historical and social context and has evolved its own particular knowledge, beliefs, values, practices and language. There are strengths and limitations within each domain but there is also the potential for miscommunication, confusion and even conflict when trying to work across sectors with professionals from other disciplines. As Audre Lorde once said,

"It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences."
AUDRE LORDE, *Our Dead Behind Us: Poems*

In this section we explore the different frameworks and beliefs that have shaped current practices in the violence against women, mental health and substance use sectors, in the hope that by understanding where we have come from, we can better determine where next we will go.

A BRIEF OVERVIEW OF THE MOVEMENT TO END VIOLENCE AGAINST WOMEN IN CANADA

The early years: Breaking the silence

Building upon work begun by the early suffragists, the post-war movement to end violence against women started from the grassroots advocacy of feminists demanding that the state, institutions and communities take steps to acknowledge and respond to the problems of rape and wife assault in women's lives. It was in the late 1960s that issues of violence towards women came out from behind closed doors and women started talking publicly about what they were experiencing in their private lives. This process was described both as "breaking the silence," and "consciousness raising." Women soon organized and started taking collective action with the goal of ending the violence that occurs in the home or "private" life as well as sexualized violence in all spheres of life. A major theme of this advocacy and organizing involved naming the violence as gendered, that is, disproportionately perpetrated by men against women, and of challenging the public/private split which taught women not to disclose what happened "behind closed doors."

Feminists demonstrated that there were social and political explanations for men's violence towards women. Violence against women was identified as an

outcome of the social structure and ideology of male domination[1] and as such, a tool of patriarchy. A battered women's movement, linked to the general women's movement began organizing shelters and crisis centers as safe havens for women in abusive situations as early as 1964.[2]

During this period feminists named rape as a gendered crime of sexual violence against women, founded rape crisis centres and lobbied effectively for changes in laws, legal processes and police practices. These changes in policies and procedures were guided by the voices of women who had experienced violence and by a philosophical approach that centralized victim safety.[3]

It was recognized that women faced the greatest risk of being murdered or seriously injured when they tried to escape their abusers. Some abusive men would track down their victims and punish them physically for trying to flee and in some cases women were killed.[4] Safe houses and shelters were developed so women and their children could find refuge from their abusers.

The movement to end violence against women expanded as feminists exposed the multiple forms of violence including wife assault, sexual assault, sexual harassment in the workplace, child sexual abuse and incest, same sex partner abuse and dating violence. Expanding the analysis further still, feminist advocates and scholars critically examined prostitution and pornography as practices of violence against and exploitation of women. Pornography and prostitution were identified as expressions of male dominance over women and of entrenched attitudes of men's entitlement to access women's sexuality – women's bodies and sexuality were treated as instruments for men's sexual gratification which legitimized violence against women.

In addition to naming widespread but previously unspoken practices of gendered violence, the anti-violence movement viewed violence against women as part of the "conscious process of intimidation by which all men keep all women in a state of fear."[5] This viewpoint helped women recognize and name the social control aspect of men's violence, the role played by fear in women's lives, the restrictions placed on movements and liberty, and the need to manage the threat of sexual intrusion of men, both known and not. All of this was recognized as contributing to women's inequality.

There has never been a unified, singular anti violence movement in Canada (or elsewhere for that matter). Instead, there are groups and individuals organizing and working from different analyses of violence and using different strategies for social change – some grassroots, some more institutionalized.

Successes of the movement to end violence against women

The violence against women movement has been highly successful and effective on many fronts. There is now widespread recognition, nationally and internationally, that domestic violence and sexual assault are significant social problems. Government, police, and other institutions have been sensitized to the issues of violence against women and have had to develop policies and programs and allocate resources to respond to the problem.

A range of crucially important achievements characterize the work of the movement to end violence against women. These include:

- A philosophical approach that centralizes victim safety and challenges victim blaming.[6]
- A recognition of the social control dimension of men's violence which helps contextualize and validate women's ongoing feelings of fear and anxiety.
- Research showing that women trying to escape their abusers face the greatest risk of serious injury or death at the hand of their abuser, countering the idea that women should "simply leave."

- An analysis of power and control.
- An understanding of how domination and oppression shapes and limits women's choices and behaviours.
- A prioritization of the voices and experiences of women who experience violence in the creation of the policies and procedures developed to serve them.
- An emphasis on recognizing and promoting victim agency.
- A focus on community response and accountability to end violence against women.
- A focus on the social conditions that create and perpetuate violence in order to develop strategies for change.

Additionally, over a period of decades in Canada, significant and successful law reform has been achieved, particularly in relation to sexual assault and sexual assault trials. The criminal justice system has also been made more responsive to domestic violence through the establishment of coordinated committees made up of legal, service provider and community constituencies, through the establishment of specialized courts, and through enhanced judicial and police training on the issues.

Mandated police practices, such as the implementation of pro-arrest policies and prosecution of domestic violence cases, have helped make what was once a private problem into a social and legal one deserving of public attention and criminal sanction. Risk assessments and the recognition that women need extra protection in order to escape violent male partners are considered essential components of an effective criminal justice system response to violence against women in intimate relationships.

Recent shifts toward an expanded feminist framework to address violence against women

While gender and patriarchy remain central to a feminist analysis, other major relationships of inequality have become central to the struggle to end women's inequality. Intersectional feminism is an approach that recognizes the ways multiple categories of identity – race, class, sexual orientation, sexual identity, and ability, for example – interact with each other and the systems of oppression and marginalization. Feminist theory and practice is based on the knowledge that effective responses to violence against women considers gender oppression in combination with other forms of discrimination such as race, ethnicity, class, citizenship, sexuality and physical and mental ability/disability.[7]

The expanding role of shelters

During the 1970s and 1980s women's shelters and programs for women who had experienced abuse expanded and new core services and programs were developed to meet the needs of assaulted women, including crisis lines and safe houses. A push for more adequate second stage housing for women wanting to permanently leave violent male partners has also been an essential part of the shelter movement.

Children's services were also included in the shelter movement since women most often fled to the safety of a shelter with their children. Services for children tried to help children understand what had happened to them and assisted children in developing non-violent interpersonal skills.

Support services included the development of self-help programs based on the belief that with support and information women can make informed choices. Many early programs focused on empowerment groups. In fact, a core tenet of counselling offered in domestic violence shelters is a model which both recognizes the ways in which inequality and oppression shape and limit women's life choices, and encourages empowerment for women, in both individual and collective terms.

Shelter programs have also worked to connect women with legal services to provide them with essential information about protection orders, criminal

prosecution, child custody issues and divorce proceedings. The domestic violence shelter movement has played a broader role in providing community education and training, raising awareness in communities about violence against women, its causes and impacts, as well as lobbying government for more effective solutions to end violence against women.

The shift from social change to social service

A significant trend in the violence against women movement, particularly noted within the shelter system, has been a shift away from a more radical agenda to a more traditional social service delivery model with characteristics of professionalization and a more individualistic approach.[8 9 10] With this shift came a focus on providing more individual counselling and a diminished effort on advocacy and social change. In other words, a significant depoliticization of the issues. Shelters struggle to maintain their advocacy efforts while increasingly focusing on counselling for individual personal change.

An ongoing challenge in the delivery of services to women who experience violence is how to take a practical approach to meeting their needs while simultaneously working to achieve long-term social and political change. It should be noted that individual counselling can include feminist and anti-oppression approaches that incorporate strategies for working toward and advocating for social and political change. Paul Kivel argues that non-profitization has successfully diverted the energy of people and organizations committed to social change work into social services.[11] This is a problem because the needs of those who experience violence will endlessly tap the time, energy and resources of advocates unless social change is achieved.

With the change in focus to individual care, shelter and violence against women workers are addressing a range of other difficulties facing the women they serve, including mental health or substance use problems, but may do so in isolation and without support from the other sectors or systems. Addressing mental health or substance use problems with women can put shelter workers, in particular, in a conflictual relationship with residents. In these situations, the shelter worker's primary role, offering support and safety, could become one of monitoring and controlling the woman's behavior (to ensure it is not self-destructive or that it doesn't compromise the requirements of the safe house). The result is that women who have a mental health or substance use problem may not be able to, or may choose not to, access the safety of the shelter.

Individual healing as well as violence prevention initiatives, including public education and other strategies designed to challenge and change social attitudes and behaviours towards violence against women are urgently needed.

In conclusion, the advocacy, educational, research, and service delivery work of those associated with the movements to end violence against women has led to unprecedented accomplishments. Yet much more remains to be done.

Something To Think About

What has helped shape your philosophy, values, and opinions about women who have experienced domestic violence? In what ways might these influence the way you work?

A BRIEF OVERVIEW OF MENTAL HEALTH IN CANADA

Over the years, there has been little consideration of sex- and gender-specific mental health and illness issues, other than in negative ways that have embodied sexist stereotypes and reflected male dominated discourses or patriarchal power. This has been particularly difficult for women, as practices and diagnoses have historically been oppressive or restrictive, building on stereotypes or understanding of women's bodies and minds, as well as overlooking

patterns of women's experiences that contribute to poor mental health or that negatively affect access to mental health services.[12] For example, experiences of domestic violence or sexual assault and their sequelae, more often experienced by women, were generally not identified or included in understanding behaviours. Reproductive mental health is another area where women have specific issues resulting from stresses of pregnancy and childbirth, or mid life changes.

Historical mental health frameworks

Over time, mental health and mental illness have been understood through a range of lenses. For example, prior to the 19th century, those who exhibited different behaviours were often thought to be possessed by demons or "mad." Women were particularly identified as "witches" or demonized around reproductive functions. In the era of early psychoanalysis, especially Freudian approaches, "hysteria" was often used as a catchall diagnosis for women's symptoms.

Biomedical approach

Subsequent to these historical approaches, the disease model emerged to characterize individuals with mental health problems as ill with disorders-such as anxiety, depression, post traumatic stress disorder, eating disorders, bipolar disorder or schizophrenia. They were identified through clinical assessments of symptoms and behaviours, most often by members of the medical profession such as psychiatrists, physicians, nurses or psychologists. This approach implies that with a diagnosis of a disease, there is a treatment, and potentially a cure. Ultimately, formal diagnoses of illness or problem are made, using the Diagnostic and Statistical Manual (DSM),[13] a compilation of diagnostic categories. It is updated from time to time, fine tuning the diagnostic criteria for illnesses or conditions or deleting or adding new ones. This process reflects the evolution of knowledge and social understanding of conditions, and frequently leads to debate and contested diagnoses. Diagnoses also have led to the rise of psychopharmacology as a key response to mental health problems. The processes and politicization of the development of diagnostic categories in the DSM has been challenged by feminists, such as Paula Caplan and Judith Lewis Herman, who have decried the medicalization of women's health through the creation of illnesses such as Premenstrual Dysphoric Disorder (PMDD).[14]

Social construction of mental illness

A social construction of mental illness is a broad and critical approach, founded on the recognition that the definitions of deviant behaviour are temporally and culturally produced, and, that non-normative responses to experiences that are problematic in life can be seen as rational. Broadly, this approach also questions the efficacy of the disease model, raising concerns about the impact of labeling on individuals, their health and well-being. Thomas Ssasz pioneered the critique of the construct of mental illness, preferring to name aberrant behaviours as responses to "problems in living."[15] This approach highlights the key role of societal and political trends and opinions in defining what mental health and illness are, and what form societal responses might take. These elements explain or contextualize the shifts in both defining and responding to mental health issues over history. For example, asylums were created to remove individuals with mental illnesses from regular society, and to provide secure, safe and healthy environments for them. More recently, de-institutionalization has been a common policy response in mental health care, and it is justified in terms of reintegration and recovery goals.[16] However, as Morrow et al. illustrate, this response can be reversed to initiate re-institutionalization or similar policies for social control as opposed to treatment motives.[17]

Biopsychosocial approach

This approach recognizes the contribution of all elements of a person's body, life and context to their

mental health and/or illness. Recognition of the interactivity of the biopsychosocial elements can potentially lead to a more robust model of identification and response to mental health and/or illness issues. In addition, the distinction between mental health and mental illness, specifically the distinction between normal responses to life, versus deviant or abnormal responses, becomes more blurred under this approach. An example is the higher risk women face for violence, sexual assault and related trauma, and their higher rates of anxiety and depression or post-traumatic stress, which may result. A biopsychosocial approach implies that a range of factors causes or contributes to both the experience of mental health/illness as well as to its response/ treatment. It also opens the door to understanding the contribution of external factors (such as stress or trauma) in conjunction with internal factors (such as genetics of biology) and their interactivity.

Social determinants of health

The determinants of health approach has gained more prominence in the past two decades, culminating in Health Canada and the Public Health Agency of Canada (PHAC, 2009[18]) endorsing this perspective. The determinants of health include:

- income and social status
- social support networks
- education and literacy
- employment/working conditions
- social environments
- physical environments
- personal health practices and coping skills
- healthy child development
- biology and genetic endowment
- health services
- gender
- culture

A recent World Health Organization Commission on the social determinants underscored the importance of this perspective in broadening the global understanding of health, and more importantly reducing health inequities.[19] It is increasingly evident that these social determinants affect an individual's or group's ability to seek and achieve physical and mental health and affects access to health care services. The term, intersectionality, is often used to describe the impact of the simultaneous interaction of various factors (such as gender, race, class etc) or processes (racism, sexism etc) on an individual's health.

Recently the Mental Health Commission of Canada produced a Mental Health Strategy (**www.mentalhealthcommission.ca**), which takes a public health approach to promoting mental health and wellbeing and providing supports and services to people with mental health problems.[20] A public health approach implies that mental health, like physical health, can be improved upon in anyone, with the provision of the right information, encouragement and supports. This notion also embodies a prevention goal; that is keeping the population mentally healthy is a tangible and important goal and will enhance human and economic health in Canada. A public health approach emphasizes both prevention and treatment, and in ideal circumstances, embodies a population based mental health promotion component. The underlying assumption is that mental health problems can be prevented or minimized, that anyone's mental health can be improved, and that there are opportunities for improving mental health literacy and mental hygiene through population based programs, messages and interventions. Having sound mental health is one way to prevent some mental health problems or illnesses from developing.

These broad goals do not always manifest in gendered ways, or in ways that address diverse life experiences or group affiliations and identities. Health promotion has generally been gender blind, omitting integrated understandings of the effects of gender on health, and access to health-promoting behaviours and opportunities.[21] Furthermore, the issues of differing vulnerabilities or levels of resilience also play into whether or not a particular individual or group of individuals will manifest mental health or mental

illness during the life course. Finally, incidents of stress, patterns of ongoing trauma, or undergoing processes of change or victimization can instigate or challenge mental health. Often, these factors mix with genetics and biochemical characteristics, and environmental challenges to create a range of inputs to mental health and mental illness. Consequently, mental health promotion has had little bedrock to build on in defining a gender or women-sensitive practice.

Recovery frameworks

Recovery approaches assume that individuals can recover from mental health problems, with appropriate supports from their social and community networks. Although not yet specifically conceptualized, "recovery" reflects both clinical as well as consumer input; meaning that the notion of recovery has been embraced by both, albeit differently. Clinicians who embrace recovery models tend to focus on individual symptom remission whereas consumer or peer initiated recovery models emphasize social recovery, or "living well either with or without symptoms."[22] While there is some imprecision in the use of the term, the key element of this perspective is the assumption that living well with mental illness is possible, may involve a decrease in symptoms, but that it depends on a range of supports and remedies, individual as well as structural. In their widest sense, recovery frameworks require attention to various social processes that are not mental health inducing, such as homophobia, sexism and racism, among others, and empowerment opportunities as embodied in the peer or consumer-led movement.

In conclusion, these different approaches to understanding mental health change as public and political opinions change, and as knowledge emerges about the etiology and experience of, and responses to mental health and illness. Gendered approaches to treatment and recovery are not yet mainstream, so often the specific experiences of women, both in Canada and globally, are invisible, ignored and unaddressed.

Something To Think About

What has helped shape your philosophy, values, and opinions about women who have mental health problems? In what ways might these influence the way you work?

A BRIEF OVERVIEW OF SUBSTANCE USE IN CANADA

Mood altering substances have been used over centuries to heighten the senses, deaden pain, help individuals feel relaxed, stimulated, or euphoric and as part of religious ceremonies. Substances that are currently illegal were once commonly accessible. Coca Cola, for example, contained cocaine until 1903.[23] Throughout the 1800s, cocaine and cocaine-infused products were widely available and women were advised to use opiates to treat a host of "female problems."[24] It wasn't until the early 1900's that countries, including Canada, began to enact legislation to prohibit the exchange of some substances such as opiates or narcotics, creating a hierarchy of licit and illicit drugs.

The focus in the substance use field has often been on men's alcohol and illicit substance use.[25] Before 1970 less than 50 studies on women's substance use had been published. Since the 1970s, a number of factors, both positive and negative, have brought increased attention to women's substance use. With the marketing of "minor" tranquilizers such as Valium, feminist activists and researchers were able to highlight the long existing practice of overprescribing legal, addictive substances to women (for example, "It's Just Your Nerves" educational package produced by Health Canada in the late 1970s). Second wave feminists also advocated for comprehensive women's substance treatment programs that integrated counselling and support for other issues such as gender-based violence, child care, housing, transportation needs, HIV care, and pregnancy and reproductive health issues.[26] [27] On the other hand, virulent

censure has been directed at pregnant substance using women, with its roots in the US anti-drug policies, and still in evidence today.[28 29 30] Overall, the gender gap in alcohol and illicit substance use is closing. There is also increasing attention to the health risks associated with alcohol, tobacco and other substances on women's bodies.[31 32 33]

Frameworks associated with substance use and addiction

The substance use field has competing frameworks in operation, based on three differing conceptions of the foundations of substance use and addiction. Over time, the three views have had varying levels of prominence, but all remain in operation to some degree. The three views are:

- Moral view – substance use and addiction are related to weak will and moral failure.
- Medical view – addiction is seen as a chronic disease or, more recently, as a brain disorder.
- Social Determinant/Public Health view – substance use and addiction are grounded in social determinants of health such as violence and trauma, isolation and other forms of social disconnection and vary by determinants such as age, gender, income, and education.

We have evidence of these views in action in the coverage of the recent Supreme Court ruling about the safe injection site in Vancouver. Representatives of the federal government responded to the ruling by citing their preferences for punishing drug dealers and providing abstinence-oriented treatment only, a response based in moral and medical oriented views of substance use. The advocates for Insite, a supervised injection site in Vancouver, responded from a public health view. The mayor of Vancouver said;

"Addiction is a health issue, not a criminal issue. Research, and now the law, confirms our position that safe injection sites such as InSite perform an important health care role in the lives of people living with chronic addiction-related problems.

Insite connects people to detox treatment services, counselling and medical help, while saving lives, reducing overdoses and reducing HIV and other infections."

GREGOR ROBERTSON, (CBC, Sept. 30, 2011)

There is perhaps no territory more contested than addiction and practitioners are likely to encounter challenges as they help women navigate support related to substance use problems. And there is probably no field which has made as many shifts in practice paradigms in the past decade.

Here we describe: key shifts in addictions thinking/practice in the past decade; implications of the moral, medical and public health frameworks for treatment systems; understanding Canadian substance use service systems; and how this affects practitioners working with women on violence, mental health and substance use concerns.

Recent shifts in addictions thinking/practice

A continuum of substance use

Often in the past, substance use was conceptualized in a binary way, as either recreational use or substance abuse, licit or illicit. Now the field operates with a more nuanced continuum view.

Women's substance use

The vast majority of people with substance use problems do not access traditional "treatment" such as outpatient counselling or residential treatment. And in the past, even people who wanted treatment were often turned away unless they were willing to commit to complete abstinence from all substances. In recent years, the substance use field has come to take into account the range of needs of women with substance use problems, from life saving efforts, to stabilization, to healing and reintegration. And those in the field have come to realize that their role is both to work with people who are ready to change as well

as to help people become ready and actively prepare for change. Diagram 2 (see below), depicts the matrix of substance use related services that respect these two dimensions of readiness and goals for change.[34]

Related to providing a continuum of care is the increased use of evidence based counselling approaches by substance use counsellors that are based in collaborative and consumer driven approaches, such as Motivational Interviewing[35] and Client Directed Outcome Informed (CDOI)[36] clinical work. As such, while reality television continues to give the impression that substance use interventions need to be confrontational, directive and shaming to be effective, the practice by professionals is moving in the entirely opposite direction.

Over the past two decades in Canada and internationally, more attention has been brought to women's substance use and the significant sex/gender differences in biological responses to substances, pathways to substance use problems and addiction, social factors and influences, as well as challenges in accessing and completing treatment.[37] [38] Important studies on the links between women's substance use, mental health concerns and violence, and the implications for treatment have been undertaken[39] and the promotion of gender-based analysis in the field is ongoing.[40]

Diagram 2

	Saving Lives	Stabilization	Healing	Reintegration
Not ready to change	• Outreach • 24 hour crises interventions	• Outreach • Needle exchange • Safe injection facilities	• Brief intervention • Medical treatments	
Thinking about change	• 24 hour sobering shelter • Wet housing	• Low threshold methadone • Drop in day programming • Damp housing support	• Withdrawal management • Brief counselling	
Ready to change		• Drug maintenance • Damp skill development • Dry pretx housing	• Long term counselling and day treatment • Residential treatment	• Aftercare counselling and relapse prevention • Supported housing
Reinforcing change				• Workforce integration programs • Disability services

Harm reduction and treatment comprising a continuum of response

Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society.[41] The guiding principles of harm reduction suggested by The Centre for Addiction and Mental Health (CAMH) are: focus on harms, prioritize goals, flexibility and maximization of goals, supporting the autonomy of the individual, and evaluation outcomes for that individual. From Diagram 2 it is also clear that services that help people reduce the harms associated with substance use are not antithetical to treatment. Both are important and necessary parts of a responsive and effective system of support. These principles are not dissimilar to those espoused by anti-violence services.

Alcohol and tobacco (legal drugs) are most harmful to women's health

Attention is often focused on illicit drugs but in fact alcohol and tobacco are linked to more negative health problems for women – such as breast cancer, other forms of cancer, heart conditions, osteoporosis and innumerable other health problems.[42 43 44 45 46 47] Cancer and heart conditions are the diseases with the highest mortality rates for women. Women who have experienced violence as well as those with mental health problems are most likely to use alcohol and tobacco. Given this, it is important that we shift our gaze and support from illicit substances only when working with women. In addition, it is important to acknowledge how common it is for women to have difficulties associated with psychoactive medications they have been prescribed for violence, mental health, and substance use problems.[48 49 50]

Women's bodies are more susceptible to the effects of alcohol, tobacco, and other drugs, and women develop many substance-related health problems earlier than men, called a telescoped development. Often women are not aware of the very significant health impacts of alcohol beyond liver disease. Cardiovascular disease, endocrine disease, obesity, diabetes mellitus, osteoporosis, breast cancer and many other cancers all have associations with use of alcohol above low risk guideline levels.[51 52] Conditions associated with smoking include pulmonary disease (including lung cancer), cardiovascular disease, breast cancer, cancers of the reproductive system and many other cancers and health concerns.[53 54] Given the significant health problems associated with women's use of alcohol, tobacco and illicit drugs, and given that rates of alcohol use are increasing, it is critical that women's service providers are confident and competent with discussing substance use with women and supporting change.

Merging of substance use and mental health systems and increasing attention to neurobiology of addiction

Increasing attention (through commissions and consumer advocacy groups) has been brought to how mental health and addictions have been marginalized in health care despite the large number of affected Canadians and the serious social and economic implications. In many jurisdictions in Canada, mental health and substance use care has been integrated in an effort to reduce isolation and fragmentation and support broader health focused support. In some jurisdictions, mental health and addictions treatment is offered in conjunction with primary health care in expanded clinic settings. This has both pros and cons. This can bring the advantage of greatly increasing access to substance use support, and at the same time can force support into a narrower medical model, over a broader bio-psycho-social-spiritual approach.

A related development is the increasing attention to the neurobiology of addiction.[55] The American Society of Addiction Medicine recently updated its definition of addiction to "a primary, chronic disease of brain reward, motivation, memory and related circuitry."[56] While helpful in leveraging the shift from a moral view of addiction, this development can also result in a narrow (pharmacological) response divorced from the determinants of health.

Multiple frameworks, multiple approaches

One result of the multiple frameworks in operation is that approaches to treatment and care vary widely, and it is often difficult for those outside the field to understand the range of treatment, support and criminal legal responses. Experts have recently identified five tiers of treatment and support that comprise an effective system, responsive to the differing levels of acuity and chronicity of people's substance use problems, their readiness to change, service preferences, and gender and diversity (see Diagram 3 below). The five tiers encompass services from community based support services, to brief interventions by a broad range of professionals, to harm reduction oriented interventions, to structured treatment options.[57]

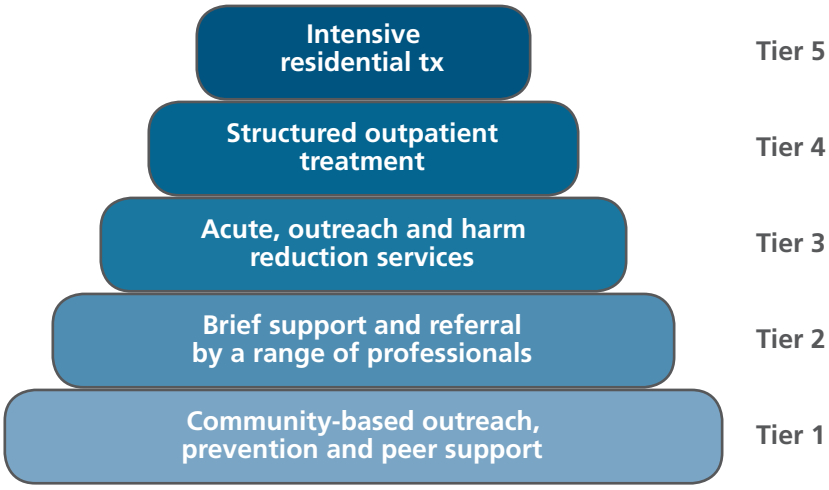
It is important to note that the doorways to care in this new conceptualization of a treatment and support system are in a number of different sectors. "These sectors (e.g., addiction treatment sector, primary care) differ in a number of different ways, including the types of problems to which they respond (e.g., chronic substance misuse), the types of people they serve (defined for e.g., by age), the ways people access the services within (e.g., referral, walk-in, outreach), and the workforces they employ (e.g., physicians, nurses, social workers, counsellors)."[58]

The key to the responses advocated in the National Treatment Strategy as well as Ontario's Mental Health and Addictions Strategy is that supports and services are needed that *identify, support,* and *engage* people with substance use problems, regardless of which door a person enters.[59]

Something To Think About

What has helped shape your philosophy, values, and opinions about women who have substance use problems? In what ways do these influence the way you work?

Diagram 3



ENVISIONING A WAY FORWARD: TRAUMA-INFORMED SERVICES AND SYSTEMS OF CARE

In trauma-informed services, there is attention in policies, practices and staff relational approaches to safety and empowerment for the service user. Safety is created in every interaction, and confrontational approaches are avoided.

Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on trauma survivor's safety, choice and control.[60] They create a treatment culture of nonviolence, learning, and collaboration.[61] Working in a trauma-informed way does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize needs for physical and emotional safety, as well as choice and control in decisions affecting one's treatment.

Trauma-informed care takes into account the impact of adverse life experiences and violence on an individual's life – her relationships, feelings, thoughts, and behaviours. It emphasizes resiliency and strength, recognizes behaviours that look like problems are attempts at coping, and gives priority to ensuring the patient or client has a sense of safety with her health care provider.

Increased awareness of the links among experiences of violence/trauma, mental health and substance use problems has services and service systems considering how to make services and programs more sensitive to the needs of those with co-occurring problems.[62] [63] A multi-site study in the US entitled the Women co-occurring Disorders and Violence Study has highlighted how helpful integrated support can be for women, how it involves a paradigm shift, and does not necessarily cost more.[64] [65] In Canada, there is national and provincial interest in making systems of care more violence and trauma-informed.[66] [67] [68]

To learn more about trauma-informed services, visit the Trauma-Informed website for the toolkit, The Trauma Toolkit, at: **http://www.trauma-informed.ca/**

Something To Think About

Do the people you work with share your philosophy, values and practices in working with women? What has contributed to the similarities or differences among staff members?

Something To Think About

How might these philosophies and frameworks create challenges for women who experience co-occurring problems? In what ways could you work to minimize those challenges?

References

[1] Brownmiller, S. (1975). *Against our will: Men, women, rape.* New York: Simon and Schuster.

[2] Bumiller, K. (2008). *In an abusive state: How neoliberalism appropriated the feminist movement against sexual violence.* Durham, NC: Duke University Press.

[3] NiCarthy, G. (1982). *Getting free: A handbook for women in abusive relationships.* Seattle, WA: Seal Press.

[4] Jones, A. (1994). *Next time she'll be dead: Battering & how to stop it.* Boston, MS: Beacon Press.

[5] Brownmiller, S. (1975). *Against our will: Men, women, rape.* New York: Simon and Schuster.

[6] Pence, E.L., & Shepard, M.F. (1999). An introduction: Developing a coordinated community response. In M.F. Shepard & E.L. Pence (Eds.) *Coordinating community responses to domestic violence: Lessons from Duluth and beyond.* Thousand Oaks: Sage Publications, Inc.

[7] Price, L.S. (2005). *Feminist frameworks: Building theory on violence against women.* Halifax, N.S.: Fernwood.

[8] MacLeod, L. (1989). *Wife battering and the web of hope: Progress, dilemmas, and visions of prevention.* Ottawa, ON: Health and Welfare Canada.

[9] Bumiller, K. (2008). *In an abusive state: How neoliberalism appropriated the feminist movement against sexual violence.* Durham, NC: Duke University Press.

[10] Walker, G.A. (1990). *Family violence and the women's movement.* Toronto, ON: University of Toronto Press.

[11] Kivel, P. (2007). Social service or social change? In Incite! Women of Color Against Violence (Ed.) *The revolution will not be funded: Beyond the non-profit industrial complex.* Cambridge, MA: South End Press.

[12] Firsten, T. (1991). Violence in the lives of women on psych wards. *Canadian Woman Studies, 11*(4), 45-48.

[13] American Psychiatric Association. *American Psychiatric Association DSM-5 Development.* Arlington, VA: American Psychiatric Association. Retrieved from **www.dsm5.org**

[14] Caplan, P.J. (n.d.) *Premenstrual mental illness: The truth about Serafem.* Washington, DC: The Network News, National Women's Health Network. Retrieved from **www.paulajcaplan.net/files/Nwhn_sarafem_ar.doc**

[15] Szasz, T.S. (1960). The myth of mental illness. *American Psychologist, 15*(2), 113-118.

[16] Morrow, M., Dagg, P.K.B., & Pederson, A. (2008). Is deinstitutionalization a "failed experiment"? The ethics of re-institutionalization. *Journal of Ethics in Mental Health, 3*(2), 1-7.

[17] Morrow, M., Dagg, P.K.B., & Pederson, A. (2008). Is deinstitutionalization a "failed experiment"? The ethics of re-institutionalization. *Journal of Ethics in Mental Health, 3*(2), 1-7.

[18] Public Health Agency of Canada. (2011). *What determines health?* Retrieved from **http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php**

[19] CSDH. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the commission on social determinants of health.* Geneva: World Health Organization. Retrieved from **http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf**

[20] Mental Health Commission of Canada. (2009). *Toward recovery and well-being: A framework for a mental health strategy for Canada.* Calgary, AB: Mental Health Commission of Canada. Retrieved from **http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf**

[21] Gelb, K., Pederson, A., & Greaves, L. (2011). How have health promotion frameworks considered gender? *Health Promotion International*. doi: 10.1093/heapro/dar087.

[22] Weisser, J., Morrow, M., & Jamer, B. (2011). *A critical exploration of social inequities in the mental health recovery literature.* Vancouver, BC: Centre for the Study of Gender, Social Inequities, and Mental Health (CGSM).

[23] Musto, D.F. (1999). *The American disease: Origins of narcotic control.* Oxford: University Press.

[24] Kandall, S.R. (2010). Women and drug addiction: A historical perspective. *Journal of Addictive Diseases, 29*(2), 117-126. doi: 10.1080/10550881003684491.

[25] Kandall, S.R. (2010). Women and drug addiction: A historical perspective. *Journal of Addictive Diseases, 29*(2), 117-126. doi: 10.1080/10550881003684491.

[26] Drabble, L. (1996). Elements of effective services for women in recovery: Implications for clinicians and program supervisors. *Journal of Chemical Dependency Treatment, 6*(1/2), 1-21.

[27] Finkelstein, N., Kennedy, C., Thomas, K., & Kearns, M. (1997). *Gender-specific substance abuse treatment.* Rockville, MD: Center for Substance Abuse Prevention.

[28] Boyd, S.C. (2006). *From witches to crack moms: Women, drug law, and policy.* Durham, NC: Carolina Academic Press.

[29] Greaves, L., & Poole, N. (2005). Victimized or validated? Responses to substance-using pregnant women. *Canadian Women's Studies, 24*(1), 87-92.

[30] Flavin, J., & Paltrow, L.M. (2010). Punishing pregnant drug-using women: Defying law, medicine, and common sense. *Journal of Addictive Diseases, 29*(2), 231-244. doi: 10.1080/10550881003684830.

[31] Kay, A., Taylor, T.E., Barthwell, A.G., Wichelecki, J., & Leopold, V. (2010). Substance use and women's health. *Journal of Addictive Diseases, 29*(2), 139-163. doi: 10.1080/10550881003684640.

[32] U.S. Department of Health and Human Services. (2001). *Women and smoking: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services.

[33] Keyes, K.M., Grant, B.F., & Hasin, D.S. (2008). Evidence for a closing gender gap in alcohol use, abuse, and dependence in the United States population. *Drug and Alcohol Dependence, 93*(1-2), 21-29.

[34] Addictions Task Group. (2001). *Weaving threads together: A new approach to address addictions in BC.* Vancouver, BC: Kaiser Youth Foundation. Retrieved from **http://www.health.gov.bc.ca/library/publications/year/2001/MHA_WeavingThreadsTogether.pdf**

[35] Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing (second edition): Preparing people for change.* New York, NY: The Guilford Press.

[36] Duncan, B.L., Miller, S.D., & Hubble, M.A. (Eds.). (1999). *The heart & soul of change: What works in therapy.* Washington, DC: American Psychological Association

[37] Tuchman, E. (2010). Women and addiction: The importance of gender issues in substance abuse research. *Journal of Addictive Diseases, 29*(2), 127-138. doi: 10.1080/10550881003684582.

[38] Poole, N., & Greaves, L. (Eds.). (2007). *Highs & lows: Canadian perspectives on women and substance use.* Toronto, ON: Centre for Addiction and Mental Health.

[39] Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S., & Heckman, J. (2004). *Enhancing substance abuse recovery through integrated trauma treatment.* Sarasota, FL: National Trauma Consortium.
Retrieved from **http://www.nationaltraumaconsortium.org/documents/IntegratedTrauma.pdf**

[40] Dell, C.A., & Poole, N. (2009). *Applying a sex/gender/diversity-based analysis within the national framework for action to reduce the harms associated with alcohol and other drugs and substances in Canada.* Ottawa, ON: Canadian Centre on Substance Abuse.
Retrieved from **http://www.nationalframework-cadrenational.ca/images/uploads/file/sex-diversity-paper-bil.pdf**

[41] Centre for Addiction and Mental Health. (2002). *CAMH position on harm reduction: Its meaning and applications for substance use issues.* Toronto, ON: Centre for Addiction and Mental Health.
Retrieved from **http://www.camh.net/Public_policy/Public_policy_papers/publicpolicy_harmreduc2002.html**

[42] U.S. Department of Health and Human Services. (2001). *Women and smoking: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services.

[43] Kovacs, E.J., & Messingham, K.A.N. (2002). Influence of alcohol and gender on immune response. *Alcohol Research & Health, 26*(4), 257-263.

[44] Emanuele, M.A., Wezeman, F., & Emanuele, N.V. (2002). Alcohol's effects on female reproductive function. *Alcohol Research & Health, 26*(4), 274-281.

[45] Sampson, H.W. (2002). Alcohol and other factors affecting osteoporosis risk in women. *Alcohol Research & Health, 26*(4), 292-298.

[46] Register, T.C., Cline, J.M., & Shively, C.A. (2002). Health issues in postmenopausal women who drink. *Alcohol Research & Health, 26*(4), 299-307.

[47] Sohrabji, F. (2002). Neurodegeneration in women. *Alcohol Research & Health, 26*(4), 316-318.

[48] Currie, J.C. (2003). *Manufacturing addiction: The over-prescription of benzodiazepines and sleeping pills to women in Canada.* Vancouver, BC: British Columbia Centre of Excellence for Women's Health.
Retrieved from **http://www.bccewh.bc.ca/publications-resources/documents/manufacturingaddiction.pdf**

[49] Women and Health Protection. (2005). *SSRI antidepressants: Their place in women's lives.* Toronto, ON: Women and Health Protection.
Retrieved from **http://www.whp-apsf.ca/en/documents/ssri.html**

[50] Rochon Ford, A., & Saibil, D. (Eds.). (2010). *The push to prescribe: Women & Canadian drug policy.* Toronto, ON: The Women's Press.

[51] Kay, A., Taylor, T.E., Barthwell, A.G., Wichelecki, J., & Leopold, V. (2010). Substance use and women's health. *Journal of Addictive Diseases, 29*(2), 139-163. doi: 10.1080/10550881003684640.

[52] National Institute on Alcohol Abuse and Alcoholism. (2004). Alcohol - An important women's health issue. *Alcohol Alert, 62*.
Retrieved from **http://pubs.niaaa.nih.gov/publications/aa62/aa62.htm**

[53] Kay, A., Taylor, T.E., Barthwell, A.G., Wichelecki, J., & Leopold, V. (2010). Substance use and women's health. *Journal of Addictive Diseases, 29*(2), 139-163. doi: 10.1080/10550881003684640.

[54] U.S. Department of Health and Human Services. (2001). *Women and smoking: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services.

[55] National Institute on Drug Abuse. (2010). *Drugs, brains, and behavior: The science of addiction*. Rockville, MD: National Institutes of Health. Retrieved from **http://drugabuse.gov/scienceofaddiction/sciofaddiction.pdf**

[56] American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction.* Chevy Chase, MD: American Society of Addiction Medicine. Retrieved from **http://www.asam.org/1DEFINITION_OF_ADDICTION_LONG_4-11.pdf**

[57] National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: Recommendations for a national treatment strategy.* Ottawa, ON: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. Retrieved from **http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf**

[58] Ross, D., Skinner, W., & Brown, D. (2007). *Responding to the risks and harms of problem substance use: Rethinking the continuum of care.* Vancouver, BC: BC Mental Health and Addictions Services and Centre for Addiction and Mental Health.

[59] National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: Recommendations for a national treatment strategy.* Ottawa, ON: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. Retrieved from **http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf**

[60] Harris, M., & Fallot, R. (2001). *Using trauma theory to design service systems.* San Francisco, CA: Jossey Bass.

[61] Bloom, S.L., & Yanosy-Sreedhar, S. (2008). The Sanctuary Model of trauma-informed organizational change. *Reclaiming Children & Youth, 17*(3), 48-53.

[62] Hopper, E.K., Bassuk, E.L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, 80-100. Retrieved from **http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf**

[63] Elliot, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., & Reed, B.G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477. doi: 10.1002/jcop.20063.

[64] Domino, M.E., Morrissey, J.P., Nadlicki-Patterson, T., & Chung, S. (2005). Service costs for women with co-occurring disorders and trauma. *Journal of Substance Abuse Treatment, 28*(2), 135-143. doi: 10.1016/j.jsat.2004.08.011.

[65] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). *Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study.* Delmar, NY: Policy Research Associates, Inc. Retrieved from **http://www.nationaltraumaconsortium.org/documents/Lessons_Final.pdf**

[66] Poole, N. & Urquhart, C. (2009). *Trauma-informed approaches in addictions treatment, gendering the National framework series (Vol. 1).* Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Retrieved from **http://www.coalescing-vc.org/virtualLearning/section6/documents/TraumaDG1.6forweb.pdf**

[67] Talbot, C., Poole, N., Nathoo, T., Unsworth, R., & Smylie, D. (2011). *Coalescing on women and substance use: Trauma-informed online tool.* Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Retrieved from **http://www.coalescing-vc.org/virtualLearning/documents/trauma-informed-online-tool.pdf**

[68] Poole, N. (2012). *Essentials of trauma-informed care.* Ottawa, ON: The Canadian Network of Substance Abuse and Allied Professionals. Retrieved from **http://www.cnsaap.ca/SiteCollectionDocuments/PT-Trauma-informed-Care-2012-01-en.pdf**

SECTION TWO:
DOMESTIC VIOLENCE, MENTAL HEALTH AND SUBSTANCE USE

I don't think we should underestimate the value of having to confront our biases and acknowledge them. So, you know for people who work in mental health for example, to understand what abuse is. And, "when you think of an abused woman, what do you think of?" And to look at our own biases around substances…what does an alcoholic look like? And mental health biases.
(ROUND TABLE PARTICIPANT, RENFREW, ON)

There is growing recognition that domestic violence, mental health, and substance use problems are often experienced concurrently.[1 2 3 4 5 6] In order to effectively support women, it is important to understand and appreciate how these issues are interrelated and their impact on women's lives and help-seeking. However, few individuals have sufficient knowledge or have received training on these co-occurring problems to automatically and consistently consider the ways in which they may be interconnected in any one woman's life.[7]

Something To Think About

What are some common myths about women who experience domestic violence, mental health and substance use problems?

Addressing this knowledge gap is the purpose of this training, but before examining their many complex interconnections, it may be useful to start with a clear understanding of each problem on its own.

WHAT IS DOMESTIC VIOLENCE?

Domestic violence is also known as intimate partner violence or woman abuse. The term domestic violence or DV is widely used in governmental initiatives in Ontario and Canada and will be the term used in this document to describe a pattern of behaviour used by an intimate partner (most frequently male) to gain power and control over their partner (most frequently female). An intimate partner could be a husband, common-law spouse, ex-spouse or same-sex partner.[8] This pattern of behaviour may include:

Physical Abuse:

The most obvious form of abuse and usually the most easily identifiable; it includes any unwanted physical contact, punching, hitting, slapping, restraining, holding or hugging when not wanted, pulling hair, pushing around, hitting with objects, choking, kicking, shoving, pinching, physically restraining, burning, using weapons, breaking bones, abandoning in a dangerous place, caring for her in abusive ways like giving too much medication, confining her, withholding food, taking away assistive devices such as hearing aid or wheel chairs, holding a deaf person's hands so she is not able to sign, etc. Some abusers are careful to inflict injury in areas that do not bruise easily or are not readily visible.

Sexual Abuse:

Includes any form of unwanted sexual behaviour or use of her/his sexuality to control her. Examples include: insisting on having sex however and whenever desired including rape, inappropriate touching, violating her/his personal space (i.e. watching during personal routines), not having control over her/his own sexual reproduction (i.e. being prevented from using contraception or being forced or prohibited from having an abortion), forced use of pornography, withholding sex, denying information about sexuality/sexual health, forcing her into prostitution, exposing her to sexually transmitted diseases.

Emotional/Psychological Abuse:

Involves a range of behaviours and tactics aimed at eroding her self-esteem and instilling fear and compliance without using physical violence. Examples of this include name calling, de-valuing, using social privilege and power, victim blaming, minimizing and denying the abuse, playing mind games, threats and intimidating tactics, destruction of property and pets, threats to hurt or kill, isolating her, constantly monitoring her whereabouts, interfering with employment, denying access to necessary services, threats by partner to commit suicide, threatening to withdraw immigration sponsorship, stalking.

Economic Abuse:

May include controlling access to resources (i.e. money, basic necessities), withholding money, not involving one in decisions about money, making her beg for money, hidden/secret bank accounts, preventing her from working, taking money away, expecting the woman/man to manage household on an inadequate budget, forcing her to lie or defraud government assistance, threatening to have her cut off of government assistance, refusing to work and living off her income.

Spiritual Abuse:

Includes mocking, putting down, or attacking her spiritual beliefs/practices or denying her practice; forcing her to join/remain in a particular spiritual organization; using belief systems to control and manipulate her.

While DV may be perpetrated by either men or women, the majority of victims (83%) are women.[9] Women have also reported experiencing more serious forms of violence and more serious consequences of violence than men.[10] [11] Family Violence in Canada: A Statistical Profile, 2009 highlights the following gender differences:[12]

- Women reported "more severe" forms of violence.
- Women reported repeated victimization.
- Women were more likely than men to be injured by a partner.
- Women were more likely than men to report negative emotional consequences as a result of the violence.
- Women were more likely to experience forms of violence that came to the attention of the police.
- Women were much more likely to report fear that their lives were in danger.

In 2009 the World Health Organization (WHO) stated that "violence against women is a major public health problem and a violation of human rights." The prevalence of DV is astounding worldwide. Based on findings from a WHO study, up to 71% of women reported physical or sexual violence by a husband or partner and as many as 1 in 5 women and 1 in 10 men reported experiencing sexual abuse as children.[13] Canadian women also experience DV at alarming rates.

The Power and Control Wheel (see Diagram 1, page 31) has been used to illustrate the various forms of behaviour that perpetrators of abuse use to keep a woman feeling fearful, powerless, and helpless.

Did you know?

Approximately 1 in 3 women in Canada have experienced violence in their adult lives and 1 in 10 are presently experiencing violence.[15]

In Canada, 50% of all women have experienced at least one incident of physical or sexual violence since the age of 16.[16]

About 80% of sex trafficking victims in Canada are women and girls.[17]

On average, every 6 days a woman in Canada is killed by her intimate partner. In 2009, 67 women were murdered by a current or former spouse or boyfriend.[18]

61% of all Canadians say they personally know at least one woman who has been sexually or physically assaulted.[19]

Diagram 1

POWER AND CONTROL WHEEL[14]

Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviours by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill threat of future violent attacks and allow the abuser to take control of the woman's life and circumstances.

The Power & Control diagram is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviours, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these types of abuse. They are less identified, yet firmly establish a pattern of intimidation and control in the relationship.

Facts to consider...

DV affects women and children from all socioeconomic, ethnic, religious, educational and racial backgrounds, however, certain populations of women are at increased risk.

Aboriginal women are 4 times more likely to have experienced abuse by their partner and 8 times more likely to be killed by their intimate partner than non-Aboriginal women.[20]

Young women between the ages of 18 and 24 years are at greater risk for DV and related homicide.[21]

Women aged 15 – 24 are killed at nearly 3 times the rate for all female victims of domestic homicide.[22]

60% of women with disabilities experience some sort of violence.[23]

One in six pregnant women is abused during pregnancy.[24]

Immigrant women may be more vulnerable to DV due to economic dependence, language barriers, and a lack of knowledge about community resources.[25]

The Immigrant Power and Control Wheel (see Diagram 2, page 33) illustrates some of the tactics used by abusers against immigrant women.

What makes DV a health issue?

Research findings make it clear that DV is a health issue. Physical injuries resulting from domestic violence typically include trauma to the head, face, neck, breasts and abdomen with a concentration in areas that are readily hidden by clothing.[26] [27] The resulting injuries may include broken bones, bruises, burns, cuts and stab wounds, scrapes, scratches, imprints, bites, concussions, skull fractures, sprains, perforated ear drums, chipped or lost teeth, loss of hair, internal injuries, detached retina, voice box injuries, or firearm wounds.

However, not all injuries are physical. DV can also cause emotional harm. Victims may develop symptoms of trauma such as flashbacks, panic attacks, and trouble sleeping. They may have a hard time trusting others and being in relationships. Often they experience low self-esteem. Survivors of DV typically experience high levels of stress and anxiety over long periods of time.[28] Stress is known to trigger or exacerbate many other health issues such as cardiovascular conditions, migraine headaches, reproductive disorders, asthma, chronic pain, and some autoimmune diseases.[29] [30]

Even emotionally abusive relationships where there are low levels of physical violence are associated with significant health problems. Psychologically abused women report more symptoms, somatic disturbances and more medical visits than non-abused women.[31] Some studies report that psychological abuse is equally, if not more, harmful than physical or sexual violence;[32] [33] [34] [35] [36] certainly abused women have said they find it more difficult to heal from the effects of psychological abuse than from physical injuries.

Facts to consider...

Women who suffer ongoing physical abuse from an intimate partner are twice as likely to visit emergency departments and 2.6 times more likely to access mental health services than those who are not abused.[37]

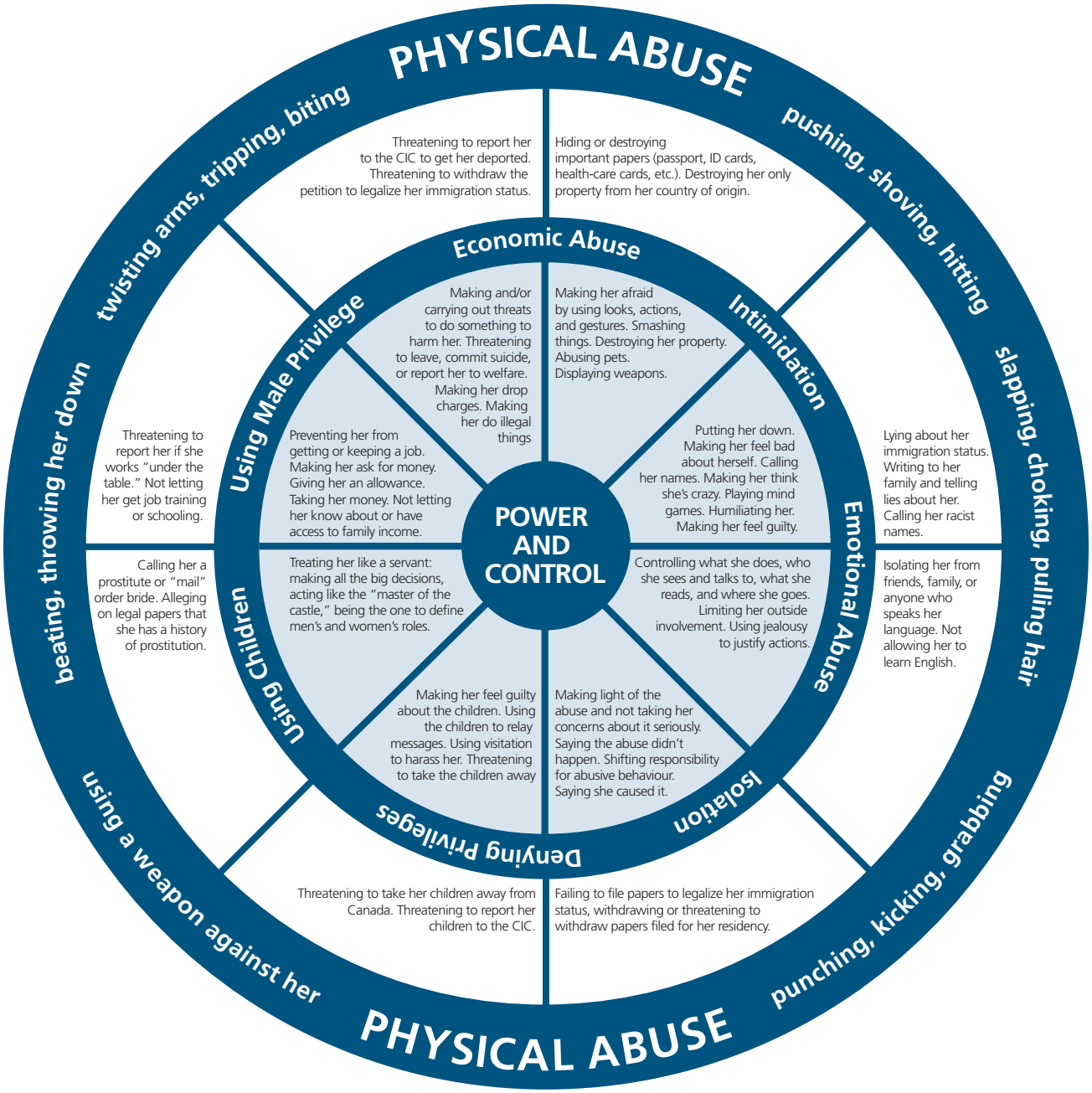
Up to 40% of women who turn up in hospital emergency departments are there because of abuse.[38]

Long-term exposure to traumatic events (such as witnessing DV) can affect children's brain development and ability to learn, and can lead to a wide range of behavioural and emotional issues such as anxiety, aggression, bullying, phobias, and insomnia.[39]

Women as compared to men were more than twice as likely to have been beaten, three times more likely to be injured, five times more likely to have been choked and five times more likely to require medical attention.[40]

Diagram 2

IMMIGRANT POWER AND CONTROL WHEEL[41]



DV also has an enormous economic impact on society as a whole. Women who have experienced violence receive medical treatment at an estimated cost to the Canadian health care system ranging from $408 million to $1.5 billion dollars.[42] However, the costs increase considerably when criminal justice, social services, lost wages and productivity are included. That results in a total of $4.2 billion per year.[43]

Indicators of DV

Some indicators of DV are easier to recognize than others. It should be remembered that no one indicator is conclusive proof of abuse. In most instances individuals will have a number of indicators. Indicators of DV have been categorized in a number of different ways:

Historical indicators - studies have shown a correlation between prior experiences of abuse and DV. These studies have related childhood abuse to a wide range of difficulties including lower self-esteem, re-victimization, depression, and drug and alcohol use.[44 45 46 47] Prior experiences with abuse include being exposed to abuse as a child or adolescent and abusive experiences with previous partners. For women past experiences of abuse can make her more vulnerable to abuse in adulthood while for men past experiences of abuse can make him more prone to using violence in his intimate relationships.

Psychological/emotional indicators - attempts to capture the long lasting impact on the mental health and emotional well being of those individuals living with abuse.

Physical indicators - may be the first that come to mind when DV is discussed but these go far beyond the black eyes and bruises. Physical indicators also refer to related ailments and conditions including sexually transmitted infections and diseases, reproductive health, including unplanned pregnancy, or miscarriage.[48]

Behavioural indicators - are observable mannerisms and ways of responding or communicating with others. Some behavioural indicators evolve from a woman's need to survive in the abusive relationship. She may use substances such as drugs, alcohol and prescription medication to cope with the emotional and psychological effects of the abuse.

Although the focus of this training is on the woman who experiences abuse, understanding the perpetrator's behaviour(s) may be useful in helping to keep her safe. Perpetrators of abuse can be found in every social class, every profession, every culture and any neighbourhood. Signs or indicators that may be present and/or observable in the perpetrator can also be categorized as:

Historical indicators - suggest that previous abuse, both as a perpetrator and victim, is linked to future perpetration. Additionally, a history of suicidal thoughts and/or attempts may also be indicative of future perpetration.

Psychological/emotional indicators - suggest that the perpetrator's behaviours and/or thoughts may be linked to future perpetration. Some examples include a negative attitude towards women, possessiveness or a history of depression.

Behavioural indicators - perpetrator cues that may suggest the woman is at an increased risk of experiencing DV.

The following table (see Table 1, below), is provided to illustrate the range of possible outcomes of experiencing DV. These lists are not exhaustive and should only be used to heighten awareness to the many possible manifestations of abuse.

Table 1: Indicators of DV Victimization

Historical	Behavioural	Psychological/Emotional
• History of physical, sexual and/or emotional abuse • History of suicidal thoughts or attempts • Signs of old, untreated physical injuries • Fearful for safety • Believes the abuser is capable of harming her and/or her children	• Nervous/guarded in presence of partner (e.g., glancing at or deferring to partner) • Substance use (e.g., tranquilizers, illegal drugs, alcohol, antidepressants) • Detailed or inconsistent explanation of injuries even before questioned • Vague about problems with partner (e.g., partner is very jealous, impulsive, stressed, depressed, aggressive, abuses alcohol or drugs) • Frequent loss of employment due to absences, lateness, productivity, harassment by partner • Deterioration in personal grooming • Frequent visits to doctor or court • Suspicion of child abuse in her role as a parent • Inability or difficulty managing household and children – detached or hostile towards children • Hiding injuries with make-up or clothing	• Depression (ranging from mild to severe) or withdrawal • Emotional fluctuations, anger, anxiety, fearful or apprehensive • Self-blame (i.e. believes she is the root cause of problems in the relationship) • Sleeping difficulties (e.g., insomnia, violent nightmares) • Difficulty focusing or motivating self • Anxiety • Low self-esteem/self-confidence • Lacks sense of self-worth • Confused thinking/inability to make decisions • Difficulty setting goals • Discuss or attempt suicide • Eating disorders • Feelings of helplessness

Physical	Sexual
• Unexplained injuries • Frequent need to replace personal items or assistive devices as they are often destroyed by partner during abusive episodes (e.g., clothing, glasses, hearing aids) • Stress-related and/or vague symptoms (e.g., insomnia, nightmares, anxiety, extreme fatigue, back pain, headaches, gastrointestinal conditions) • Damage to home • Most common sites of injury include head, neck, torso, abdomen, genitals, and fingers • Broken bones: wrist, rib, ring finger, jaw, clavicle, cheek • Bruises: bilateral or multiple contusions, arms, legs, buttocks, breasts, chest, abdomen, head, eyes, lips, cheeks, neck, back • Burns: cigarette burns, scalding, burns from stove/fireplace, acid • Cuts and stab wounds: anywhere on body • Abrasions: scrapes, friction burns, fingernail scratches or punctures, ring imprints, mouth cuts • Bites: often on breasts and other sexual areas, arms, legs, necks • Lacerations: on skin over bony areas, internal tearing • Sprains • Perforated ear drums • Chipped or lost teeth • Loss of hair • Internal injuries • Detached retina • Voice box injuries • Firearm wounds • Hyperventilation	• Sexually transmitted diseases and infections • Miscarriages • Stillbirths • Pregnancy • Pre-term babies • Low birth weight babies

The following table (see Table 2, below) is provided to illustrate the range of possible perpetrator characteristics. These lists are not exhaustive and should only be used to heighten awareness to the many possible manifestations of perpetrator characteristics.

Table 2: Indicators of DV Perpetration

Historical	Behavioural	Psychological/Emotional
• History of abuse toward previous partners/children • Survivor of physical, sexual or emotional abuse • History of suicidal thoughts or attempts	• Answers questions that are directed at the woman • Insists on acting as interpreter • A suspicion of child abuse or sexual abuse involving children • Drug/alcohol abuse • Harms pets and/or personal property • Economic control/deprivation (e.g. keeping woman short of money) • Isolation from family, friends and the community at large • Use of community or religious pressure to keep woman submissive • Denial or minimization of abuse • Overly curious about what woman has told service provider • Boastful about role as family provider • Difficulty finding/sustaining employment • Inadequate or withholding care – over medicating • Hiding or damaging assistive devices or medication	• Impulsiveness • Temper tantrums • Jealousy • Possessiveness • Excessive dependence on partner • Immaturity • Rigid views on the roles of men and women • Negative attitude towards women • Mental health issues (especially depression)

Indicators of lethal DV

Ontario's Domestic Violence Death Review Committee (DVDRC) was established in 2003 to "assist the Office of the Chief Coroner with the investigation and review of deaths involving domestic violence with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general" (DVDRC 2010). To date, it has reviewed 111 cases, some with multiple victims including perpetrator suicides, for a total of 178 deaths. Their annual reports highlight risk factors associated with lethality. These are the most common risk factors associated with femicide as determined by the DVDRC in 2010:[49]

Actual or pending separation	14	77%
History of domestic violence	13	72%
Obsessive behaviour displayed by perpetrator	10	56%
Perpetrator depressed in professionals' (i.e. physician, counsellor) and/or non-professionals' opinion (i.e. family, friends, etc)	9	50%
Victim had intuitive sense of fear	8	44%
Prior threats/attempts to commit suicide	7	39%

For a more extensive list of indicators associated with lethality, please consult the 2010 DVDRC report at:
http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec094225.pdf

Something To Think About

If you were to speak with a group of young people about healthy relationships, what would be your key message(s)?

WHAT IS MENTAL HEALTH/MENTAL ILLNESS?

The WHO defines "mental health as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[50] Mental health is about learning the coping skills to deal with life's ups and downs the best we can.[51] Multiple social, psychological, and biological factors determine the level of mental health of a person at any point in time. Mental health can be considered to exist along a continuum from good mental health through poor mental health to mental ill health, or what is often called, mental illness. Poor mental health is associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations.[52]

It has been estimated that 1 in 5 Canadians (20%) will personally experience a mental health problem at some point during their lifetime; the other 4 will have a family member, friend, or colleague who will.[53] However, some Canadians are more at risk of developing a mental health problem than others. For example, Canadians in the lowest income group are 3-4 times more likely to report poor or fair mental health when compared with those in the highest income group.[54] Women are 1.5 times more likely to meet the criteria for a mood or anxiety disorder than men.[55]

There are numerous studies that have found that women's mental health problems are associated with increased risk of violence victimization. Various hypotheses have been suggested, for example that women with poor mental health may be less vigilant, more prone to misuse substances, may appear more vulnerable to perpetrators, and are less likely to seek help.[56 57 58 59 60 61] But it is important to know that not all women who experience violence or abuse at the hands of their intimate partners go on to develop a diagnosed mental illness or mental health problem.

Common mental health problems experienced by women

Depression is a mood disorder the chief symptom of which is a sad, despairing mood that persists beyond two weeks and impairs a person's performance at work, at school or in social relationships. This profoundly low mood state can be confusing because some of the symptoms of depression are behavioural, such as moving or talking slowly, while others are emotional and cognitive, such as feeling hopeless and thinking negative thoughts. Signs and symptoms of depression include:

- changes in appetite and weight
- sleep problems, either sleeping too much or too little
- loss of interest in work, hobbies, people; loss of feeling for family members and friends
- feelings of uselessness, hopelessness, excessive guilt
- preoccupation with failure(s) or inadequacies and a loss of self-esteem; certain thoughts that are obsessional and difficult to "turn off"
- agitation or loss of energy; if you feel so restless that you cannot keep still, or if you feel too tired and weak to do anything
- slowed thinking, forgetfulness, trouble concentrating and making decisions
- decreased sexual drive
- a tendency to cry easily, or having the urge to cry, but are unable to do so
- suicidal or occasionally homicidal thoughts
- at times, a loss of touch with reality, perhaps hearing voices (hallucinations) or having strange ideas (delusions)

Depressive disorders can **vary in severity**. A person who suffers for two weeks or more with fewer than five of the symptoms of major depression is diagnosed with minor depression. When someone suffers with five or more of these typical symptoms for at least two weeks, this is called a "major depressive episode." For many people, however, their struggle with depression has persisted for weeks, months or even years before they visit a doctor or mental health professional.[62] Women are twice as likely to be diagnosed with clinical depression than men.[63]

Anxiety disorders are the most common mental health problem experienced by women. According to the American Psychiatric Association (APA), there are six main categories of anxiety disorders: phobias, panic disorder (with or without agoraphobia), generalized anxiety disorder, obsessive-compulsive disorder, acute stress disorder and posttraumatic stress disorder.[64] Each of these anxiety disorders is distinct in some ways, but they all share the same hallmark features:

- heightened fear
- apprehensive and tense feelings
- difficulty managing daily tasks and/or distress related to these tasks

Anxiety is related to the primitive fight or flight response that is generally activated by situations of danger. Adrenalin is released resulting in increased energy and alertness. These can include feeling nervous, tense, dizzy, sweaty, shaky or breathless. Several factors determine whether the anxiety warrants the attention of mental health professionals, including:

- the *degree* of distress caused by the anxiety symptoms
- the *level of effect* the anxiety symptoms have on a person's ability to work or study, socialize and manage daily tasks
- the *context* in which the anxiety occurs[65]

Post Traumatic Stress Disorder (PTSD) is a reaction to trauma and has been defined by the APA as "a severe anxiety disorder that can develop after exposure to an extreme traumatic stressor involving direct personal experience of an event that involves:

- actual or threatened death or serious injury, or other threat to one's physical well-being
- witnessing an event that involves death
- injury, or a threat to the physical well-being of another person
- learning about unexpected or violent death
- serious harm or threat of death or injury experienced by a family member or other close associate

Trauma is an experience that is emotionally painful, distressful or shocking, which often results in lasting mental and physical effects. Three main categories of traumatic events can each lead to a different trauma response and each responds to a different form of treatment:

- recent acute traumatic events (e.g., car crash, single violent assault, etc.)
- past single traumatic events (e.g., rape, death of spouse, accident) and events that last a discrete period of time (e.g., a natural disaster)
- long-term chronic abuse (e.g., ongoing DV, childhood sexual, or other abuse, including neglect, growing up in violent environment)[66]

As Judith Lewis Herman has written, "the conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma."[67] Survivors of trauma may re-experience the trauma mentally, emotionally and physically. Trying to avoid these reminders (or triggers) can make survivors tense much of the time particularly as they also remain highly attuned to other possible danger. Individuals with PTSD are not able to control their feelings of panic, of wanting to run away, wanting to defend themselves, or wanting to be prepared for something terrible or painful.[68] Some symptoms include:

- persistent re-experiencing of the traumatic event
- dissociative states (lasting from a few seconds to several hours or longer)
- intense psychological distress or physiological reactivity in response to triggers
- persistent avoidance of thoughts, feelings or conversations about the traumatic event and activities, situations, or people who arouse recollections of it
- diminished interest or participation in previously enjoyed activities
- feeling detached or estranged from other people, or a markedly reduced ability to feel emotions, especially intimacy, tenderness, and sexuality
- increased anxiety or increased arousal (e.g. difficulty falling or staying asleep, nightmares, and exaggerated startle response). Some individuals report irritability or outbursts of anger or difficulty concentrating or completing tasks[69]

Facts to consider…

Only 1/3 of those who need mental health support services receive the help they need.[70]

Although mental illnesses account for 15% of the burden of disease, these illnesses receive just 5.5% of Canadian health dollars.[71]

In terms of health care and lost productivity, the estimated cost of mental illness to the Canadian economy is $51 billion.[72]

One study found that more than 50% of women who experienced DV suffered some form of mental health problems and nearly two thirds of women who experienced "severe" DV had one or more diagnosed mental health disorders.[73]

Something To Think About

If mental health problems are common among Canadians, why are there so many stigmas associated with having a mental illness? How are these stigmas perpetuated?

WHAT IS SUBSTANCE USE/SUBSTANCE MISUSE?

For the purposes of this training, substances include both licit drugs such as alcohol, tobacco, prescription drugs, solvents, etc. and illicit drugs such as marijuana, crack, heroin, cocaine, etc. While substance use is often considered within discussions of mental health in general, treatment protocols and programs generally consider substance use as distinct from other mental health problems.

It is difficult to define harmful substance use, substance misuse, substance dependence, or addiction. Traditional definitions have relied upon criteria that include frequency of use, substance tolerance, and withdrawal symptoms to determine the presence of harmful substance use or addiction. For example, in the spring of 2011, The American Society of Addiction Medicine adopted this definition:

> Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
>
> Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[73]

The APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) created an appendix to include a disorder called Substance Dependence. This is defined as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. Markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for Withdrawal from the specific substances)
   b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
6. Important social, occupational, or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)[75]

In contrast to these medically oriented definitions, treatment settings, such as the Jean Tweed Centre in Toronto, have moved away from the stigmatizing language of pathology and adopted instead a behavioural approach to identifying when a woman may have a substance use problem. In British Columbia, as illustrated in the previous section, a Spectrum of Psychoactive Substance Use (Diagram 1, see page 21) was developed to describe a range of substance use behaviours from beneficial through to chronic dependence.

In this training we will focus on the behaviours associated with problematic substance use rather than attempting to diagnose or determine the presence of a dependency or addiction.

Did you know?

Alcohol intoxication is associated with 40-50% of traffic fatalities, 25-35% of nonfatal motor vehicle injuries, and 64% of fires. Alcohol is present in nearly 50% of homicides, either in the victim or the perpetrator.[76]

In Ontario 7.3% of residents are heavy frequent drinkers, defined as five drinks or more, more than once a week in the past year.

And, 12.4% of residents indicate they have used cannabis in the past year.

1.3% have used crack or cocaine.[77]

Amongst Canadians, 26% of those 15 years and older reported using an opioid pain reliever, a stimulant, or sedative or tranquilizer in the past year while 0.3% reported using any of these drugs to get high in the past year.[78]

One more thing to think about: The social determinants of health

We can talk about the ideal but then you also have to be realistic. It's going to be very hard for me to work on somebody's addiction issues, or mental health issues, or abuse issues, if they don't have housing or transportation.

Round Table participant, Owen Sound, ON

I think we need to have a sociopolitical context to trauma and to the impact of trauma on women and children and to look through that frame in terms of this work. [Consider] systems

of oppression; patriarchy, or racism, or heterosexism or so on and so on. Understand that women are responding to that and trying to cope with the impact of that rather than pathologizing her ways of coping. Then it's not about her as an individual, it's a societal issue.

Round Table participant, Toronto, ON

The interrelationship between violence, mental health and substance use is complex, and examining these issues requires that we also take into consideration the social and political world each woman inhabits. Understanding this context is crucial to our understanding her and how best to support her.

For example, research indicates that women who experience the subtle hurts associated with racism, ableism, heterosexism, being homeless, poor or otherwise more vulnerable, face additional stressors adding to their psychological distress[79 80 81] and affecting their help-seeking behaviour.[82 83 84]

Health is not just determined by the absence of illness but also by a number of other factors or *determinants* that influence well-being. In Canada, the social determinants of health have been identified as income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture, that affect the health of individuals. Many of these also influence and impact women's experiences of DV, mental health, or substance use and the services or help she is able to access for these problems.

Not surprisingly, income is one of the most important determinants of health because of the impact and effect money has on many of the other determinants. Almost one in five women lives in poverty.[85] Of those Canadian women living in poverty, immigrant women, Aboriginal women, women of colour and women with disabilities are over-represented. Not having enough money can make it difficult to leave an abusive relationship. One quarter to one half of all women leaving an abusive relationship encounter housing problems; more than a third of DV survivors report becoming homeless as a result of trying to end the abusive relationship.[86] Similarly, women with mental health and/or substance use problems frequently experience economic hardship and social isolation, issues that adversely affect their ability to access and remain in treatment programs.[87]

Something To Think About

How have you defined "addiction" in the past? Was this definition similar to or different from the ones provided?

Intersection among DV, mental health and substance use

It is increasingly clear that DV is associated with a range of mental health and substance use problems. These co-occurring problems are the focus of Section 3.

References

[1] Nehls, N., & Sallmann, J. (2005). Women living with a history of physical and/or sexual abuse, substance use, and mental health problems. *Qualitative Health Research, 15*(3), 365-381. doi: 10.1177/1049732304272917.

[2] Morrissey, J.P., Ellis, A.R., Gatz, M., Amaro, H., Reed, B.G., Savage, A., et al. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *Journal of Substance Abuse Treatment, 28*(2), 121-133. doi: 10.1016/j.jsat.2004.08.012.

[3] BC Society of Transition Houses. (2011). *Report on violence against women, mental health and substance use.* Vancouver, BC: BC Society of Transition Houses. Retrieved from **http://www.octevaw-cocvff.ca/en/pdf/reports/BCSTH_CWF_Report.pdf**

[4] Parkes, T., Welch, C., Besla, K., Leavitt, S., Ziegler, M., MacDougall, A., et al. (2007). *Freedom from violence: Tools for working with trauma, mental health and substance use.* Vancouver, BC: Ending Violence Association of BC. Retrieved from **http://www.endingviolence.org/node/459**

[5] The Stella Project. (2007). *Domestic violence, drugs and alcohol: Good practice guidelines.* London, UK: Against Violence & Abuse. Retrieved from **http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/stella-project-toolkit-(2007).aspx**

[6] Cory, J., Godard, L., Abi-Jaoude, A., & Wallace, L. (2010). *Building bridges: Linking women abuse, substance use, and mental ill health.* Vancouver, BC: Woman Abuse Response Program. Retrieved from **http://www.bcwomens.ca/NR/rdonlyres/C1AA97BC-FAAB-40E9-972D-F377EE729080/45188/BB_summaryreport.pdf**

[7] Morrow, M. (2002). *Violence and trauma in the lives of women with serious mental illness: Current practices in service provision in British Columbia.* Vancouver, BC: The British Columbia Centre of Excellence in Women's Health. Retrieved from **http://www.wwda.org.au/morrow1.pdf**

[8] Occupational Health & Safety Council of Ontario Workplace Violence Prevention Series. (2010). *Domestic violence doesn't stop when your worker arrives at work: What employers need to know to help.* Ontario: Occupational Health & Safety Council of Ontario. Retrieved from **http://www.osach.ca/products/resrcdoc/OHSCO_EmployerBooklet.pdf**

[9] Burns, M., & Taylor-Butts, A. (2009). *A profile of Canada's shelters for abused women. Family violence in Canada: A statistical profile.* Ottawa, ON: Canadian Centre for Justice Statistics (Catalogue no. 85-224-x).

[10] Patterson, J. (2003). *Family violence in Canada: A statistical profile*. Ottawa, ON: Statistics Canada.

[11] Bunge, V., & Locke, D. (2000). *Family violence in Canada: A statistical profile.* Ottawa, ON: Canadian Centre for Justice Statistics.

[12] Burns, M., & Taylor-Butts, A. (2009). *A profile of Canada's shelters for abused women. Family violence in Canada: A statistical profile.* Ottawa, ON: Canadian Centre for Justice Statistics (Catalogue no. 85-224-x).

[13] World Health Organization. (2011). *Violence against women: Intimate partner and sexual violence against women. Fact sheet no. 239.* Geneva: World Health Organization. Retrieved from **http://www.who.int/mediacentre/factsheets/fs239/en/index.html**

[14] Domestic Abuse Intervention Project. (undated). *Power and control wheel.* Duluth, MN: Domestic Abuse Intervention Project. Retrieved from **http://www.womenscollegehospital.ca/assets/legacy/wch/pdfs/4083_PowerControlwheel.pdf**

[15] World Health Organization. (2002). *Intimate partner violence fact sheet.* Geneva: World Health Organization. Retrieved from **http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/ipvfacts.pdf**

[16] Statistics Canada (1993). *The violence against women survey,* The Daily, November 18, 1993. (Catalogue no. 11001E).

[17] Canadian Women's Foundation. (2010). *Scope of CWF trafficking task force.* Toronto, ON: Canadian Women's Foundation.

[18] Beattie, S. & Cotter, A. (2010). *Homicide in Canada.* Juristat, 30(3) (Catalogue no. 85-002-X). Ottawa, ON: Statistics Canada. Retrieved from **http://www.statcan.gc.ca/pub/85-002-x/2010003/article/11352-eng.pdf**

[19] Canadian Women's Foundation. (2007). *Decima survey.* Toronto, ON: Canadian Women's Foundation.

[20] Ontario Native Women's Association & Ontario Federation of Indian Friendship Centres. (2007). *A strategic framework to end violence against Aboriginal women.* Toronto, ON: Ontario Native Women's Association & Ontario Federation of Indian Friendship Centres.

[21] Toronto Police Service. (2009). *Annual statistical report.* Toronto, ON: Toronto Police Service. Retrieved from **http://www.torontopolice.on.ca/publications/files/reports/2009statsreport.pdf**

[22] Toronto Police Service. (2009). *Annual statistical report.* Toronto, ON: Toronto Police Service. Retrieved from **http://www.torontopolice.on.ca/publications/files/reports/2009statsreport.pdf**

[23] DisAbled Women's Network Canada. (undated). *Women with disabilities and violence factsheet.* Montreal, QC: DisAbled Women's Network Canada. Retrieved from **http://www.dawncanada.net/pdf/WomenDisabilitiesViolence.pdf**

[24] Parkes, T., Welch, C., Besla, K., Leavitt, S., Ziegler, M., MacDougall, A., et al. (2007). *Freedom from violence: Tools for working with trauma, mental health and substance use.* Vancouver, BC: Ending Violence Association of BC. Retrieved from **http://www.endingviolence.org/node/459**

[25] Status of Women Canada. (undated). *Violence against women fact sheet.* Ottawa, ON: Status of Women Canada.

[26] Sweet, D. (1996). Recognizing and intervening in domestic violence: Proactive role for dentistry. *Medscape Women's Health, 1*(6), 3.

[27] Campbell, J.C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi: 10.1016/S0140-6736(02)08336-8.

[28] Moeller, T.P., Bachmann, G.A., & Moeller, J.R. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: Long-term health consequences for women. *Child Abuse and Neglect, 17*(5), 623-640. doi: 10.1016/j.chiabu.2007.01.003.

[29] Campbell, J.C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi: 10.1016/S0140-6736(02)08336-8.

[30] Doherty, D. (2002). *Health effects of family violence overview paper.* Ottawa, ON: National Clearinghouse on Family Violence. Retrieved from **http://www.crvawc.ca/documents/healtheffects-eng_000.pdf**

[31] Kernic, M.A., Wolf, M.E., & Holt, V.L. (2000). Rates and relative risk of hospital admission among women in violent intimate partner relationships. *American Journal of Public Health, 90*(9), 1416-1420.

[32] Follingstad, D.R., Rutledge, L.L., Berg, B.J., Hause, E.S., & Polek, D.S. (1990). The role of emotional abuse in physically abusive relationships. *Journal of Family Violence, 5*(2), 107-120.

[33] Coker, A.L., Smith, P.H., Bethea, L., King, M.R., & McKeown, R.E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9*(5), 451-457.

[34] Hyman, I., Mason, R., Berman, H., Guruge, S., Manuel, L., Kanagaratnam, P., et al. (2006). Perceptions of and responses to intimate partner violence among Tamil women in Toronto. *Canadian Women's Studies, 25*(1&2), 145-150.

[35] Thompson, R.S., Bonomi, A.E., Anderson, M., Reid, R.J., Dimer, J.A., Carrell, D., & Rivara, F.P. (2006). Intimate partner violence: Prevalence, types, and chronicity in older women. *American Journal of Preventative Medicine, 30*(6), 447-457. doi: 10.1016/j.amepre.2006.01.016.

[36] Else, L.T., Wonderlich, S.A., Beatty, W.W., Christie, D.W., & Staton, R.D. (1993). Personality characteristics of men who physically abuse women. *Hospital and Community Psychiatry, 44*(1), 54-58.

[37] Bonomi, A.E., Anderson, M.L., Rivara, F.P., & Thompson, R.S. (2009). Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *Health Services Research, 44*(3), 1052-1067. doi: 10.1111/j.1475-6773.2009.00955.x.

[38] Burbridge, K. (1996, April 9). Hospitals join together in aid of abused women in Peterborough. *Peterborough This Week.*

[39] Alberta Children and Youth Services. (2008). *Child abuse/children exposed to family violence information sheet.* Alberta: Alberta Children and Youth Services. Retrieved from **http://www.child.alberta.ca/home/images/familyviolence/doc_opfvb_sheet_child_colour.pdf**

[40] Patterson, J. (2003). Spousal violence. In H. Johnson & K. Au Coin (Eds.) *Family violence in Canada: A statistical profile 2003*. Ottawa, ON: Statistics Canada. Retrieved from **http://www.statcan.gc.ca/pub/85-224-x/85-224-x2003000-eng.pdf**

[41] National Center on Domestic and Sexual Violence. (undated). *Immigrant power and control wheel.* Austin, TX: National Center on Domestic and Sexual Violence. Retrieved from **http://www.endingviolence.org/files/uploads/ImmigrantWomenPCwheel.pdf**

[42] Cohen, M.M., & Maclean, H. (2004). Violence against Canadian women. *BMC Women's Health, 4*(Suppl 1), S22. doi: 10.1186/1472-6874-4-S1-S22.

[43] Statistics Canada. (2006). *Measuring violence against women: Statistical trends 2006.* Ottawa, ON: Statistics Canada. (Catalogue no. 85-570-XIE). Retrieved from **http://www.statcan.gc.ca/pub/85-570-x/85-570-x2006001-eng.pdf**

[44] Stein, J.A., Leslie, M.B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: Mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect, 26*(10), 1011-1027. doi: 10.1016/S0145-2134(02)00382-4.

[45] Felitti V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine, 14*, 245-258.

[46] Fuller-Thomson, E., Sulman, S., Brennenstuhl, S., & Merchant, M. (In Press). Functional somatic syndromes and childhood physical abuse in women: Data from a population based study. *Journal of Aggression, Maltreatment & Trauma*.

[47] Public Health Agency of Canada. (2002). *Woman abuse – Overview paper.* Ottawa, ON: Public Health Agency of Canada. Retrieved from **http://www.phac-aspc.gc.ca/ncfv-cnivf/publications/femviof-eng.php**

[48] Newberger, E.H., Barkan, S.E., Lieberman, E.S., McCormick, M.C., Yllo, K., Gary, L.T., & Schechter, S. (1992). Abuse of pregnant women and adverse birth outcomes. *The Journal of the American Medical Association, 267*(17), 2370-2372. doi: 10.1001/jama.1992.03480170096037.

[49] Office of the Chief Coroner. (2010). *Eighth annual report: Domestic violence death review committee.* Toronto, ON: Office of the Chief Coroner. Retrieved from **http://www.crvawc.ca/documents/2010report.pdf**

[50] World Health Organization. (2001a). *Strengthening mental health promotion.* Geneva: World Health Organization (Fact Sheet, No. 220).

[51] Mood Disorders Society of Canada. (2009). *Quick facts: Mental illness and addiction in Canada.* Guelph, ON: Mood Disorders Society of Canada. Retrieved from **http://www.mooddisorderscanada.ca/documents/Media%20Room/Quick%20Facts%203rd%20Edition%20Referenced%20Plain%20Text.pdf**

[52] World Health Organization. (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report.* Geneva, World Health Organization. Retrieved from **http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf**

[53] Health Canada. (2002). *A report on mental illnesses in Canada.* Ottawa, ON: Health Canada. Retrieved from **http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf**

[54] Health Canada. (2002). *A report on mental illness in Canada.* Ottawa, ON: Health Canada. Retrieved from **http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf**

[55] Statistics Canada. (2003). *Canadian Community Health Survey: Mental health and well-being.* Ottawa, ON: Statistics Canada.

[56] Burnam, M.A, Stein, J.A., Golding, J.M., Siegel, J.M., Sorenson, S.B., Forsythe, A.B., & Telles, C.A. (1988). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology, 56*(6), 843-850.

[57] Coverdale, J.H., & Turbott, S.H. (2000). Sexual and physical abuse of chronically ill psychiatric outpatients compared with a matched sample of medical outpatients. *Journal of Nervous & Mental Disease, 188*(7), 440-445. doi: 10.1097/00005053-200007000-00008.

[58] Grubaugh, A.L., Zinzow, H.M., Paul, L., Egede, L.E., & Frueh, B.C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review, 31*, 883–899. doi: 10.1016/j.cpr.2011.04.003.

[59] North, C.S., Smith, E.M., & Spitznagel, E.L. (1994). Violence and the homeless: An epidemiological study of victimization and aggression. *Journal of Traumatic Stress, 7*(1), 95-110. doi: 10.1002/jts.2490070110.

[60] Friedman, S.H. & Loue, S. (2007). Incidence and prevalence of intimate partner violence by and against women with severe mental illness. *Journal of Women's Health, 16*(4), 471-480. doi: 10.1089/jwh.2006.0115.

[61] Walton-Moss, B.J., Manganello, J., Frye, V., & Campbell, J.C. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of Community Health, 30*(5), 377-389. doi: 10.1007/s10900-005-5518-x.

[62] Centre for Addiction and Mental Health. (2009). *Info on depression.* Toronto, ON: Centre for Addiction and Mental Health. Retrieved from **http://www.camh.net/About_Addiction_Mental_Health/AMH101/top_searched_depression.html**

[63] Health Canada. (2002). *A report on mental illnesses in Canada.* Ottawa, ON: Health Canada. Retrieved from **http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf**

[64] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR).* Arlington, VA: American Psychiatric Association.

[65] Centre for Addiction and Mental Health. (2009). *Anxiety disorders.* Toronto, ON: Centre for Addiction and Mental Health. Retrieved from **http://www.camh.net/About_Addiction_Mental_Health/AMH101/top_searched_anxiety.html**

[66] Centre for Addiction and Mental Health. (2009). *Introduction to trauma.* Toronto, ON: Centre for Addiction and Mental Health. Retrieved from **http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/Pages/introduction_trauma.aspx**

[67] Herman, J.L. (1997). *Trauma and recovery: The aftermath of violence – from domestic violence to political terror.* New York, NY: Basic Books.

[68] Centre for Addiction and Mental Health. (2009). *Introduction to trauma.* Toronto, ON: Centre for Addiction and Mental Health. Retrieved from **http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/Pages/introduction_trauma.aspx**

[69] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR).* Arlington, VA: American Psychiatric Association.

[70] Statistics Canada. (2003). *Canadian Community Health Survey: Mental health and well-being*. Ottawa, ON: Statistics Canada.

[71] Institute of Health Economics. (2008). *How much should we spend on mental health?* Edmonton, AB: Institute of Health Economics. Retrieved from **http://www.ihe.ca/documents/Spending%20on%20Mental%20Health%20Final.pdf**

[72] Lim, K.L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, C.S. (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases in Canada, 28*(3), 92-98.

[73] Roberts, G.L., Lawrence, J.M., Williams, G.M., & Raphael, B. (1998). The impact of domestic violence on women's mental health. *Australian and New Zealand Journal of Public Health, 22*(7), 796-801. doi: 10.1111/j.1467-842X.1998.tb01496.x.

[74] American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction.* Chevy Chase, MD: American Society of Addiction Medicine. Retrieved from **http://www.asam.org/1DEFINITION_OF_ADDICTION_LONG_4-11.pdf**

[75] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR).* Arlington, VA: American Psychiatric Association.

[76] Lowenfels, A.B., & Miller, T.T. (1984). Alcohol and trauma. *Annals of Emergency Medicine, 13*(11), 1056-1060. doi: 10.1016/S0196-0644(84)80070-0.

[77] Adlaf, E.M., Begin, P., & Sawka, E. (Eds.). (2005). *Canadian addiction survey (CAS): A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed report.* Ottawa, ON: Canadian Centre on Substance Abuse. Retrieved from **http://www.ccsa.ca/2005%20CCSA%20Documents/ccsa-004028-2005.pdf**

[78] Statistics Canada. (2010). *Major findings from the Canadian Alcohol and drug use monitoring survey (CADMUS) 2010.* Ottawa, ON: Statistics Canada. Retrieved from **http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/index-eng.php**

[79] Paranjape, A., & Kaslow, N. (2010). Family violence exposure and health outcomes among older African American women: Do spirituality and social support play protective roles? *Journal of Women's Health, 19*(10), 1899-1904. doi: 10.1089/jwh.2009.1845.

[80] Greer, T.M., Laseter, A., & Asiamah, D. (2009). Gender as a moderator of the relation between race-related stress and mental health symptoms for African Americans. *Psychology of Women Quarterly, 33*(3), 295-307. doi: 10.1111/j.1471-6402.2009.01502.x.

[81] Chakraborty, A., & McKenzie, K. (2002). Does racial discrimination cause mental illness? *The British Journal of Psychiatry, 180*, 475-477. doi: 10.1192/bjp.180.6.475.

[82] Mason, R., Hyman, I., Berman, H., Guruge, S., Kanagaratnam, P., & Manuel, L. (2008). "Violence is an international language:" Tamil women's perceptions of intimate partner violence. *Violence Against Women, 14*(12), 1397-1412. doi: 10.1177/1077801208325096.

[83] Bui, H.N. (2003). Help-seeking behavior among abused immigrant women: A case of Vietnamese American women. *Violence Against Women, 9*(2), 207-239. doi: 10.1177/1077801202239006.

[84] Yoshihama, M. (2002). Battered women's coping strategies and psychological distress: Differences by immigration status. *American Journal of Community Psychology, 30*(3), 429-452. doi: 10.1023/A:1015393204820.

[85] Canadian Association of Social Workers. (2004). *Women's income and poverty in Canada revisited*. Ottawa, ON: Canadian Association of Social Workers. Retrieved from **http://www.rebelles.org/files/womenpoverty_e.pdf**

[86] Baker, C.K., Cook, S.L., & Norris, F.H. (2003). Domestic violence and housing problems: A contextual analysis of women's help-seeking, received informal support, and formal system response. *Violence Against Women, 9*, 754-783.

[87] Brady, T.M., & Ashley, O.S. (Eds.). (2005). *Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS).* Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Retrieved from **http://oas.samhsa.gov/womenTX/womenTX.pdf**

SECTION THREE:
THE COMPLEXITIES OF CO-OCCURRING PROBLEMS

Our clients don't simply come in with a mental health issue and that's it. There's usually more complex needs and I would like to see us moving away from the fact that we say, 'ok, it's an abuse issue, the woman's centre is a more appropriate spot, or, it's an addiction issue, send her to [the addiction service], it's a more appropriate spot. I'd like to see more cross training of staff so that I'm more trained in abuse issues, and addictions and treatment, and vice versa.

(ROUND TABLE PARTICIPANT, OWEN SOUND, ON)

A lot of times, the women who work here struggle with how to support somebody because they don't know what to do when someone has an addiction or a mental health issue.

(SHELTER FOCUS GROUP PARTICIPANT)

What is needed is good case management where everyone first parks their ego at the door. It shouldn't matter which organization becomes the manager – it should be the most logical one or the one she first approaches.

(ROUND TABLE PARTICIPANT, DRYDEN, ON)

Something To Think About

What are your personal values and beliefs as they relate to DV, mental health and substance use? Would people who know you recognize these in the way you approach your work?

DV, MENTAL HEALTH AND SUBSTANCE USE

The relationship among DV, mental health and substance use problems is both complex and multidirectional. A number of studies have been conducted to try and isolate the causal relationships with varying degrees of success. However, it is clear that women who have experienced abuse have significantly higher rates of mental health and substance use problems when compared with women who have not experienced violence.

Although there is no simple way to isolate the individual effects of each problem, it is clear that when DV co-occurs with either mental health or substance use, the negative impact is worse than for either problem on its own.[1] Different degrees of social stigma are also associated with each problem, with substance using women, particularly those with children, the most stigmatized in our communities and services.[2 3] It seems likely that women with co-occurring DV, mental health and/or substance use problems experience even greater stigma.

Many factors complicate the relationship among DV, mental health and substance use problems such as:

- Abuse characteristics (who the abuser is and his or her relationship to the victim, duration of abuse, type of abuse, etc);
- Temporal considerations (does the violence precede mental health or substance use or vice versa);
- Contextual factors (geographic locale, income, education, disability, language, ethnicity/race etc.);
- Other individual factors (stressful life events, support systems, resilience etc.)

DV increases the risk of mental health and substance use problems

You have to look at the big picture of the person involved. Did the mental health issue exist before the domestic violence? Did the addiction

exist before? Is it a result of living in a relationship where there is domestic violence? What's the family history? Did the individual suffer from mental illness and as a result become homeless and then end up in an abusive relationship…?
(Round Table participant, Kingston, ON)

Overall, the experience of DV, especially recurrent DV, markedly increases a woman's risk of developing several psychiatric disorders, such as major depressive disorder, PTSD, and generalized anxiety disorder.[4] As well, women who have experienced DV are also at increased risk of developing alcohol and substance use problems including nicotine dependence.[5]

For example, among women who have experienced DV the rates of psychosocial distress are double, and sometimes triple, those of non-abused women.[6] In fact, one study reported that among women who attended the emergency department of a large Australian hospital, 50% of those who had experienced violence were diagnosed with a mental health disorder compared to 20% of women who had not experienced DV.[7]

- 67% of women with substance use problems have a concurrent mental health problem such as PTSD, anxiety, and/or depression.[8]
- More than 50% of women in shelters experience major depression.[9]
- More than 33% of women in shelters experience PTSD.[10]

Adding further complexity, studies suggest that women who have mental health or substance use problems face increased vulnerability to violence and experience more serious effects from the abuse they do experience.[11] Women who experience both mental health and substance use problems are at greatest risk for DV when compared to women dealing with only one of these problems.[12] Negative emotional effects include feelings of hopelessness, depression, and emotional distress.[13] It should be acknowledged that there is little research on the mental health status or substance use of lesbian, gay and transgendered individuals who experience DV.

Mental health problems related to experiencing DV

You've got substance abuse counsellors without mental health training, and mental health workers without addictions…so they still can't deal with our abused clients.
(Round Table participant, Kingston, ON)

The most prevalent mental health problems related to the experience of DV include: PTSD, depression, anxiety, suicidal ideation, panic and dissociative disorders[14] (see Appendix 3-2 for further information about some of these mental health problems). Women who have experienced abuse are significantly more likely to meet the criteria for psychiatric diagnoses for PTSD, major depression, generalized anxiety, as well as alcohol and substance abuse and dependence, than non-abused women.[15] Even after controlling for lifetime victimization (meaning that other experiences of violence were not included in the analysis), women with a history of DV were more likely than women with no such histories to experience PTSD, depression, anxiety, and suicidal thoughts.[16] Although women who experience abuse may develop any of these mental health problems, the most common are PTSD and depression.[17]

A change in the demographics of women using domestic violence programs has also occurred. As new legal protections expand women's options for safety, shelters are seeing women with fewer resources — women who have experienced greater lifetime adversity and who are in greater need of mental health services — services that are not supported by current funding streams.[18]

It is estimated that between 64 – 94% of women who experience DV develop PTSD.[19] A review of 11 studies

on PTSD reported that 63.8% of women with PTSD had experienced DV; women who experience DV are 4 times more likely than non-abused women to develop PTSD.[20] Research examining the relationship between specific acts of DV (physical, sexual, emotional, etc) and PTSD is conflicting. Some studies suggest that physical violence is more likely to predict the development of PTSD, while other studies suggest that psychological or sexual types of DV are more likely to predict PTSD.[21]

Some studies report worse outcomes associated with greater frequency and severity of DV.[22] Others note that even so-called low levels of violence (such as pushing, shoving) lead to mental health problems, particularly depression.[23] [24] The relationships are hard to tease apart as there is significant co-occurrence among different types of DV.[25]

In addition to type of abuse (hitting, pushing, naming calling etc.), research suggests that greater frequency of abuse increases the likelihood that female DV victims will experience PTSD, depression, as well as substance use problems.[26] As well, prior victimization has been shown to be predictive of higher post-traumatic stress and PTSD levels for victims of DV.[27] [28]

PTSD often co-occurs with other mental health and substance use problems

PTSD is defined by the American Psychological Association as "an anxiety problem that develops in some people after extremely traumatic events, such as combat, crime, an accident or natural disaster. People with PTSD may relive the event via intrusive memories, flashbacks and nightmares; avoid anything that reminds them of the trauma; and have anxious feelings they didn't have before that are so intense their lives are disrupted."[29]

PTSD is one of many mental health outcomes for DV victims. Although there is a lack of Canadian research in this area, several studies conducted in the United States indicate significant co-occurrence between PTSD and other mental health problems, particularly depression and substance use. One study found that in 75% of women, major depression occurred in the context of PTSD,[30] suggesting that depression is often a later complication for those who experience trauma.[31] Women with both PTSD and major depression experienced more PTSD and more depressive symptoms than women with PTSD alone.[32]

- 27.9% of women with a history of PTSD reported problems with alcohol or alcohol dependence at some point in their lifetime compared to 10.55% of women without PTSD.[33]
- In the United States PTSD and substance use problems are two to three times more common in women entering substance use treatment than in men entering treatment.[34]

Women diagnosed with both PTSD and a substance use disorder tend to relapse more quickly and have less economic or social support than those without PTSD.[35] [36] [37]

There are two explanations that have been put forward to explain the high rates of co-occurring PTSD and substance use problems. The first suggests that substance misuse precedes PTSD as women seeking and using substances find themselves in risky situations. The second describes the pathway where PTSD precedes substance use, and substances are used to manage PTSD symptoms. In this scenario, substance use helps women cope with feelings related to PTSD such as intrusion, avoidance, hyper-arousal and emotional distress.[38] Alcohol or opioids, for example, may be used to manage hyper-arousal, and cocaine to increase a sense of control and power.

Women may be at greater risk than men of substance use problems following the development of PTSD,[39] because they experience higher rates of trauma and are more likely to use substances to regulate negative affect.[40] [41] [42]

Women experiencing DV are at greater risk of developing depression

According to the American Psychological Association, depression is "more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide."[43]

Women experiencing DV are at 25% more risk of developing depression than women in non-violent relationships.[44] Among women abused by their partners, rates of depression range from 17-83%,[45] with one recent meta-analysis (an analysis of multiple studies) reporting a prevalence of 47.6%.[46]

Over 50% of women who enter DV shelters experience major depression.[47] Some research suggests that the duration of abuse may be positively correlated with depression symptom severity.[48]

Researchers have investigated whether leaving the violent relationship results in decreased depressive symptoms. Some studies report women's lower levels of depression after leaving the abusive relationship[49] or after levels of violence decrease,[50] while others have found no significant improvement in depressive symptoms up to two years post relationship.[51]

Although there is less research, suicidal tendencies have been associated with experiencing DV.[52] Some research suggests that experiencing multiple types of abuse has more adverse effects than experiencing one type of abuse. For example, women who experienced sexual and physical abuse, compared to physical abuse alone, were more likely to attempt suicide.[53]

Women who experience DV more likely to experience problems related to illicit drugs, alcohol, prescription drugs or tobacco

It's a woman's choice. At the end of the day my thinking is, 'if I'm using something to help me cope with this shit, and if you can't offer me something better, then I'm going to keep my shit. Thank you very much. Because it's what I know. It's what I'm comfortable with. And it's what is working for me. Whether or not you think it's working for me, that's your issue – that's on you. But for me it's working.'
(Round Table participant, Kingston, ON)

Women who experience DV are more likely to misuse illicit drugs, alcohol, prescription drugs and tobacco compared to women who have not experienced violence.[54] [55] Women who experience sexual and physical abuse compared to physical abuse alone were also more likely to use alcohol and marijuana to cope.[56] Among women who experienced one type of gender-based violence (DV, sexual assault, rape or stalking), 23% reported a substance use problem at some point in their lives. Among women who experienced three to four types of gender-based violence, the rate of substance use rose to 47.1%, a number five times greater than among women who experience no gender-based violence.[57]

Substance abuse is like a medication for us sometimes; it helps us to cope with our depression – to escape from what he is doing to us. Recognize that it is an addiction and that we sometimes want to get out of it… but it's a way of surviving, a way of coping.
(Round Table participant, Kingston, ON)

Some research suggests that women's experience of violence precedes their mental health and/or substance use problems.[58] Approximately two-thirds of women accessing violence against women services in British Columbia, for example, reported that their problematic substance use began *after* experiencing violence in their relationships.[59]

Some research suggests that substance use co-occurs in relationships and that a woman's risk of experiencing DV is significantly higher when her partner uses alcohol or drugs.[60] [61] For example, a sample survey at police call scenes for DV in Tennessee found that 92% of abusive partners had reportedly used alcohol or other drugs on the day of the assault.[62] Another study found that the likelihood of a woman experiencing DV was significantly higher on days when her partner abuses alcohol or drugs compared to days of no alcohol or drug use by her partner.[63] Alcohol and cocaine use disorders were most strongly associated with domestic violence perpetration and a woman's risk of being injured.[64] [65] Results from accident and emergency departments suggest that DV precedes both alcohol and drug use in the majority of cases.[66]

It is important to note that alcohol use neither excuses nor predicts DV; however a woman's risk of being injured, or murdered, is greater when her partner has been drinking or using drugs.[67] [68] [69]

For more information about specific substances and their effects, see Appendix 3-3.

Something To Think About

What implications does a better understanding of the connections between DV, mental health and substance use have for your work? Consider the following:

- Assessment
- Service delivery approaches
- Referrals
- Partnership & collaborations
- Policies & practices

Did you know?

Among women diagnosed with a severe mental health disorder, there is a "high risk" of DV.[70]

Among female psychiatric inpatients 62% reported a history of physical assault by an intimate partner.[71] [72]

On average over half of women seen in a range of mental health settings either currently are or have been abused by an intimate partner, although rates vary widely among studies.[73]

Children who experience physical or sexual abuse or who are exposed to DV are at greater risk of experiencing DV and mental health issues like depression and PTSD in adulthood.[74] [75] *"It appears that the trauma is the independent variable in the relationship and that a mental illness develops after exposure to that trauma."*[76]

Combined findings from 18 independent studies on depression reported that women who experienced DV were more than three times as likely as non-abused women to experience depression.[77]

It is clear that mental health problems persist long after an abusive relationship ends. In a longitudinal study of Canadian women 18 months out of the abusive relationship, more than half reported feeling anxious, worried, sad, depressed, or had problems sleeping and nearly one third of the women were taking anti-depressants, three times more than in the general population.[78]

Negative and ongoing impacts of abuse are cumulative and affect a woman and her children. Statistics gathered in Ontario, Canada indicated that half of the babies born in the province each year are born to mothers who have experienced at least one incident of sexual/physical violence at the hands of a parent, spouse, friend or family member.[79] While it is important to acknowledge a number of challenges in examining the research on the impacts of DV on children, including the difficulties in separating the impacts of exposure to DV and the presence of other problematic family issues, a picture of children's development in the context of DV is emerging. We now know that in many instances the negative and ongoing impacts of abuse are cumulative and affect not only the individual woman but her children as well.[80]

There is a substantial body of literature examining the impact of abuse that occurs during pregnancy, childbirth, and/or the postpartum period. Evidence suggests that abuse, particularly physical violence, not only impacts the woman but can also result in newborns with lower birth weights as well as more risk of postpartum depression for mothers.[82] [83]

Children exposed to DV are at greater risk of experiencing abuse and mental health problems

Children and adolescents exposed to DV are at increased risk of developing emotional and behavioral problems, of experiencing emotional, physical and sexual abuse, and of increased exposure to the presence of other adversities in their lives.[84]

Children who witness their mother's abuse are at much greater risk of developing PTSD or exhibiting other signs of deep distress.[85] [86] However, age, coping style and severity of the violence witnessed also affect the way an individual child responds.[87]

Children exposed to DV may also experience problems in adolescence with difficulty establishing healthy dating or intimate relationships. It appears that behaviours children are exposed to in childhood are adopted in adolescence as girls tend to become victims and boys to become abusive partners.[88]

In some jurisdictions in North America, for example Ontario, Canada, children who are exposed to woman abuse are recognized to be children at risk and in need of protection even if they do not suffer physical or sexual harm themselves. Ontario's Child & Family Services Act provides for a child to be protected if that child is suffering *"emotional harm, demonstrated by serious,*

(i) anxiety,

(ii) depression,

(iii) withdrawal,

(iv) self-destructive or aggressive behaviour, or

(v) delayed development,

and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.[89]

Children impacted even when they don't witness abuse of their mother

Although development is an individual process based on both environmental as well as biological factors, it appears that in general, children exposed to DV have more anxiety, lower self-esteem and higher rates of depression (internalizing effects), as well as more behavioural difficulties (externalizing effects) than children from non abusive families, with girls exhibiting more internalizing and boys more externalizing behaviours.[90] [91] [92] [93] These difficulties develop even when the children have not actually "witnessed" any violence but are living in a family where there is DV and occurs as the child tries to make sense of their confusing family and world.[94] [95]

We also know more about the ways that DV can affect the mother-child relationship. Raising a child is far more stressful in the context of an abusive relationship where there are more negative interactions with the baby's father and more verbal aggression than for women who are not abused.[96] Fathers can consciously and systematically undermine the mother-child relationship as a way of exercising coercive control.[97] Further, the stress and depression that is a consequence of abuse can also contribute to difficulties in mothering.

When mothers are in abusive relationships there is an increased risk of attachment problems developing and

problematic parenting behaviours (from overly harsh or abusive to overly permissive or even neglectful).[98 99] Other effects of DV have also been shown to compound the stress of mothering, for example, the more severe the abuse a woman experiences, the smaller the size of her social network and thus, the greater her isolation.[100] Social isolation makes it more difficult to mother young children and can also negatively affect a child's ability to develop connections and networks beyond the nuclear family.

Impacts of DV on Children

Historical	Behavioural	Psychological/Emotional	Physical
• Prior experiences of child abuse/ sexual abuse	• Aggression (especially in boys) • Inappropriate behaviour for age or development • Overly passive/compliant (especially in girls) • Suicide attempts or discussion • Underachievement • Inability to trust • Juvenile delinquency/contact with law • Withdrawn, passive, clinging behaviour (particularly in girls and young children) • Self-destructive, accident-prone behaviour • Acting-out, escapist behaviour (particularly in teenagers) (e.g., running away, drug/alcohol abuse, prostitution) • Early pregnancy and/or marriage	• Depression • Withdrawal • Low self-esteem • Severe anxiety • Fearfulness • Failure to thrive in infancy • Sleep disturbances/night-time difficulties (e.g., insomnia, nightmares, bed-wetting, problems with bedtime) • Suspicion of parent abuse or sibling abuse • Eating disorders	• Physical complaints with no medical basis • Somatic complaints (e.g., headaches, stomach-aches, chronic colds, allergies)

Impact on children of mother's mental health problems

There is considerable evidence that children are at heightened risk of adverse consequences when their parents, particularly their mothers, have mental health problems. Infants of depressed mothers, for example, have been shown to experience significantly less secure attachment and a somewhat greater likelihood of avoidant (where a child shows no preference for the parent over a stranger) and disorganised (ambivalent feelings or lack of clear attachment to the parent) attachment.[101] In addition to attachment issues, children of depressed mothers are also more likely to experience cognitive and behavioural difficulties.[102] Research has shown that offspring of depressed mothers generally exhibit more difficult temperamental characteristics and longitudinal studies suggest that difficult child temperament is linked with depression in the child in later life.[103] In addition, mother's depression has been linked to less maternal warmth, more psychological control in parenting, and as a result, multiple child problems.[104]

Using Relational Cultural Theory,[105] Banks outlined ways that relationships are negatively affected by PTSD and trauma.[106] First, women may experience a physical trigger to remembering/re-experiencing past trauma as they attempt to move physically and emotionally closer to others. Thus the physical proximity and sensations of caring for infants, toddlers and children may be difficult for women who experience PTSD symptoms.

Second, women who have experienced trauma may lose faith in their ability to recognize and connect with "safe" people. As a result, they often isolate themselves from relationships in an attempt to protect themselves from further harm. In a study of women who had symptoms of PTSD and who had left abusive relationships, dysfunctional patterns of emotion and behavior were found in the ways they related to their children. Mothers with PTSD were more quick or impulsive in their actions toward their children; as well these mothers had a tendency to underestimate the distress experienced by their children. Some of the patterns could be expected to affect their children later in life; however, PTSD in mothers did not predict PTSD in their children, children who developed PTSD likely did so as a result of the trauma they experienced.[107]

There is also a known association between mothers with anxiety disorders and the development of anxiety disorders in children.[108] Furthermore, the type of maternal anxiety disorder (especially social phobia and generalised anxiety disorder) and its severity appear to contribute to the increased risk that children will develop anxiety.[109] Anxiety disorders in adolescents may be more common when mothers experience postpartum depression.[110]

Impact on children of parental substance use

Women with substance use problems also frequently experience social, emotional and economic deprivation, including problems with housing and employment, all of which contribute to the challenge of parenting and from a research perspective, makes it difficult to determine the differential impact of each factor on child development. The result is most research on the effects on children of parental substance use fail to consider or control for these social and contextual factors. Bearing this in mind, the negative effects of parental substance use on children that have been noted include mothers' impaired ability to appropriately 'read' their infant's facial and crying behaviours, which may impair their ability to respond appropriately.[111] The effects of this on children include poor growth and development and an increased susceptibility to substance abuse.[112 113 114]

Some studies have also found that parental substance use problems were associated with higher levels of physical and sexual abuse, as well as other forms of child maltreatment, in particular neglect. The 2001 Canadian Incidence Study of Reported Child Abuse and Neglect drew upon data from child welfare authorities to estimate the annual number of child maltreatment cases in Canada. The authors note that alcohol or drug misuse was a factor in more than 1/3 of all cases reported (34%), although not all cases were later substantiated. In those cases which warranted an investigation and were later substantiated, emotional maltreatment (58%), neglect (50%) and physical and sexual abuse (each at 40%) were the most frequent outcomes.[115] It is worth remembering, however that these data are based on those families that are involved with the child welfare system and may not reflect the general population. Data from an Ontario based population survey found that a parent's substance use problems were associated with a more than twofold increase in the risk of exposure to both childhood physical and sexual abuse, although the risk was greater if it was the father, or both parents, that had the substance use problem.[116]

For further reading on this topic: The Breaking the Cycle Compendium: Vol. 1, The Roots of Relationship, produced by Mothercraft a child development organization located in Toronto, Canada.

Mitigating the impact for children of mothers who experience DV, mental health and substance use problems

Some children fare better than others. It is important to remember that individual children's responses to challenges are dependent on many factors; factors within the child, the family and the environment.[117] Both internal factors, such as the child's own personality, as well as external factors such as

parenting practices, the presence of other supportive adults and availability of resources, contribute to resiliency. One study identified two protective factors among children who witnessed their mother's abuse but developed positive coping skills: the children were 61% more likely to have an easy temperament – defined by regularity, approachability, high adaptability, positive mood, and lower reactivity; and they had mothers who reported less depression.

Mothers with good mental health are more likely to model appropriate responses to stressful events and help their children achieve healthy emotional regulation. Interestingly, the study found that race, cognitive ability, income and surprisingly positive parenting, were not significant factors in a child's resilience.[118] Other studies suggest that resilient children are exposed to less violence and have mothers with better mental health and mothering skills.[119] [120]

To minimize the risk of long-term harm, children exposed to parental DV, mental health and substance use problems need a sense of safety and security. They also need the support of caring adults. While caring parents are the ideal caregivers of children, other adults can play a role in actively supporting children and preventing further exposure to harm.[121]

Something To Think About

Are there ways you or your organization could work to support and increase the resilience of children exposed to DV, mental health and substance use problems?

Stigma experienced by mothers with mental health or substance use problems

Mothers with mental health challenges are more likely to lose their children to child protection services than women without these challenges and in general, have few sources of formal social support, experience more poverty, greater rates of homelessness, as well as trauma and substance use problems.[122]

Something To Think About

What steps could you and your organization take to reduce the barriers women face in accessing services/treatment for co-occurring DV and mental health and/or substance use problems?

We often focus on the rights of the child or fetus while ignoring or vilifying the woman. Public discourse on pregnant women as users of alcohol, drugs and tobacco has been fundamentally judgmental, blaming and unsympathetic. In this context it has been challenging to make service systems responsive to women's pregnancy needs for information, non-judgmental brief intervention and supportive treatment.[123]

Greaves and colleagues have analyzed the various ways that the media, policy documents, and society in general talk about mothers who experience co-occurring problems. They found that common to these discourses is a focus on the rights of the child or fetus while ignoring or vilifying the women responsible for their care.[124]

Pregnant women with serious substance use problems who suddenly stop drinking are likely to experience harmful side effects of withdrawal, particularly if there is a history of past withdrawal delirium or seizures.[125] In-patient care is recommended for pregnant women experiencing withdrawal symptoms.

Barriers to treatment for mothers with substance use problems have been characterized as both internal (denial, fear of stigma, fear of separation from children, shame and low self-esteem) and external (fears of having their child apprehended, lack of residential services with childcare, lack of women only programs, transportation and access issues particularly in the north, lack of children's programs, lack of support from partner or family)[126] [127] [128] making the decision to seek treatment difficult.

Mothers with mental health problems are more likely to lose their to child protection services than mothers without these challenges and in general, have fewer sources of formal social support, experience more poverty, greater rates of homelessness, as well as trauma and substance use problems.[129] They are also more likely to be blamed or held responsible for the violence they experience.

References

[1] Becker, M.A., Noether, C.D., Larson, M.J., Gatz, M., Brown, V., Heckman, J.P., & Giard, J. (2005). Characteristics of women engaged in treatment for trauma and co-occurring disorders: Findings from a national multisite study. *Journal of Community Psychology, 33*(4), 429-443. doi: 10.1002/jcop.20061.

[2] Greaves, L., Varcoe, C., Poole, N., Morrow, M., Johnson, J., Pederson, A., & Irwin, L. (2002). *A motherhood issue: Discourses on mothering under duress.* Ottawa, ON: Status of Women Canada. Retrieved from **http://publications.gc.ca/collections/Collection/SW21-99-2002E.pdf**

[3] Greaves, L., Pederson, A., Varcoe, C., Poole, N., Morrow, M., Johnson, J., & Irwin, L. (2004). Mothering under duress: Women caught in a web of discourses. *Journal of the Association for Research on Mothers, 6*(1), 16-27.

[4] Okuda, M., Olfson, M., Hasin, D., Grant, B.F., Lin, K-H., & Blanco, C. (2011). Mental health of victims of intimate partner violence: Results from a national epidemiologic survey. *Psychiatric Services, 62*(8), 959-962. doi:10.1176/appi.ps.62.8.959.

[5] Okuda, M., Olfson, M., Hasin, D., Grant, B.F., Lin, K-H., & Blanco, C. (2011). Mental health of victims of intimate partner violence: Results from a national epidemiologic survey. *Psychiatric Services, 62*(8), 959-962. doi:10.1176/appi.ps.62.8.959.

[6] Roberts, G. L., Williams, G. M., Lawrence, J. M., & Raphael, B. (1999). How does domestic violence affect women's mental health? *Women & Health, 28*(1), 117-129. doi: 10.1300/J013v28n01_08.

[7] Ludermir, A.B., Schraiber, L.B., D'Oliveira, A.F.P., Franca-Junior, I. & Jansen, H.A. (2008). Violence against women by their intimate partner and common mental disorders. *Social Science & Medicine, 66*(4), 1008-1018. doi: 10.1016/j.socscimed.2007.10.021.

[8] Zilberman, M.L., Tavares, H., Blume, S.B., & el-Guebaly, N. (2002). Towards best practices in the treatment of women with addictive disorders. *Addictive Disorders & Their Treatment, 1*(2), 39-46. doi:10.1097/00132576-200206000-00001.

[9] 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. doi: 10.1177/0886260507312942.

[10] 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. Retrieved from **http://ezproxy.qa.proquest.com/docview/77015288?accountid=14771**

[11] Gatz, M., Russell, L.A., Grady, J., Kram-Fernandez, D., Clark, C., & Marshall, B. (2005). Women's recollections of victimization, psychological problems, and substance use. *Journal of Community Psychology, 33*(4), 479-493. doi: 10.1002/jcop.20064.

[12] McPherson, M.D., Delva, J., & Cranford, J.A. (2007). A longitudinal investigation of intimate partner violence among mothers with mental illness. *Psychiatric Services, 58*(5), 675-680. doi:10.1176/appi.ps.58.5.675.

[13] Shannon, L., Logan, T.K., Cole, J., & Walker, R. (2008). An examination of women's alcohol use and partner victimization experiences among women with protective orders. *Substance Use & Misuse, 43*(8-9), 1110-1128. doi: 10.1080/10826080801918155.

[14] Moses, D.J., Reed, B.G., Mazelis, R., & D'Ambrosio, B. (2003). *Creating trauma services for women with co-occurring disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study.* Delmar, NY: Policy Research Associates.

[15] Koss, M.P. (1990). The women's mental health research agenda: Violence against women. *American Psychologist, 45*(3), 374-380. doi: 10.1037/0003-066X.45.3.374.

[16] Pico-Alfonso, M.A., Garcia-Linares, M.I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health, 15*(5), 599-611. doi: 10.1089/jwh.2006.15.599.

[17] Ratner, P.A. (1993). The incidence of wife abuse and mental-health status in abused wives in Edmonton, Alberta. *Canadian Journal of Public Health, 84*(4), 246-249.

[18] Warshaw, C., Gugenheim, A.M., Moroney, G., & Barnes, H. (2003). Fragmented services, unmet needs: Building collaboration between the mental health and domestic violence communities. *Health Affairs, 22*(5), 230-234. doi: 10.1377/hlthaff.22.5.230.

[19] Campbell, J.C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi: 10.1016/S0140-6736(02)08336-8.

[20] Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-traumatic stress disorder (PTSD) in victims of domestic violence: A review of the research. *Trauma, Violence, & Abuse, 2*(2), 99-119. doi: 10.1177/1524838001002002001.

[21] 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. Retrieved from **http://ezproxy.qa.proquest.com/docview/77015288?accountid=14771**

[22] Vogel, L.C.M. & Marshall, L.L. (2001). PTSD symptoms and partner abuse: Low income women at risk. *Journal of Traumatic Stress, 14*(3), 569-584. doi: 10.1023/A:1011116824613

[23] Stein, M.B., & Kennedy, C. (2001). Major depressive and post-traumatic stress disorder comorbidity in female victims of intimate partner violence. *Journal of Affective Disorders, 66*(2-3), 133-138. doi: 10.1016/S0165-0327(00)00301-3.

[24] Cascardi, M., & O'Leary, K.D. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence, 7*(4), 249-259. doi: 10.1007/BF00994617.

[25] Basile, K.C., Arias, I., Desai, S., & Thompson, M.P. (2004). The differential association of intimate partner physical, sexual, psychological and stalking violence and posttraumatic stress symptoms in a nationally representative sample of women. *Journal of Traumatic Stress, 17*(5), 413-421. doi: 10.1023/B:JOTS.0000048954.50232.d8.

[26] Valentine, J.M., Rodriguez, M., Son, J.B., & Muhammad, M. (2009). Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma, Violence, & Abuse, 10*(4), 358-374. doi: 10.1177/1524838009339756.

[27] Lilly, M.M., & Graham-Bermann, S.A. (2009). Ethnicity and risk for symptoms of posttraumatic stress following intimate partner violence: Prevalence and predictors in European American and African American women. *Journal of Interpersonal Violence, 24*(1), 3-19. doi: 10.1177/0886260508314335.

[28] Campbell, R., Sullivan, C.M., & Davidson, W.S. (1995). Women who use domestic violence shelters: Changes in depression over time. *Psychology of Women's Quarterly, 19*(2), 237-255. doi: 10.1111/j.1471-6402.1995.tb00290.x.

[29] American Psychological Association. (2000). *Encyclopedia of Psychology (Vols 1-8)*. Retrieved from **http://www.apa.org/topics/ptsd/index.aspx**

[30] Stein, M.B., & Kennedy, C. (2001). Major depressive and post-traumatic stress disorder comorbidity in female victims of intimate partner violence. *Journal of Affective Disorders, 66*(2-3), 133-138. doi: 10.1016/S0165-0327(00)00301-3.

[31] Mellman, T.A., Randolph, C.A., Brawman-Mintzer, O., Flores, L.P., & Milanes, F.J. (1992). Phenomenology and course of psychiatric disorders associated with combat-related posttraumatic stress disorder. *The American Journal of Psychiatry, 149*(11), 1568-1574.

[32] Nixon, R.D.V., Resick, P.A., & Nishith, P. (2004). An exploration of comorbid depression among female victims of intimate partner violence with posttraumatic stress disorder. *Journal of Affective Disorders, 82*(2), 315-320. doi: 10.1016/j.jad.2004.01.008.

[33] Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048-1060. doi: 10.1001/archpsyc.1995.03950240066012.

[34] Najavits, L.M., Weiss, R.D., Shaw, S.R., & Muenz, L.R. (1998). "Seeking Safety:" Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*(3), 437–456. doi: 10.1023/A:1024496427434.

[35] Najavits, L.M., Weiss, R. & Shaw, S.R. (1999). A clinical profile of women with posttraumatic stress disorder and substance dependence. *Psychology of Addictive Behaviors, 13*(2), 98-104. doi: 10.1037/0893-164X.13.2.98.

[36] Ouimette, P.C., Ahrens, C., Moos, R.H., & Finney, J.W. (1997). Posttraumatic stress disorder in substance abuse patients: Relationship to 1-year posttreatment outcomes. *Psychology of Addictive Behaviors, 11*(1), 34-47. doi: 10.1037/0893-164X.11.1.34

[37] Riggs, D.S., Rukstalis, M., Volpicelli, J.R., Kalmanson, D., & Foa, E.B. (2003). Demographic and social adjustment characteristics of patients with comorbid posttraumatic stress disorder and alcohol dependence: Potential pitfalls to PTSD treatment. *Addictive Behaviors, 28*(9), 1717-1730. doi: 10.1016/j.addbeh.2003.08.044

[38] Khantzian, E.J. (1997). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. In D.L. Yalisove (Ed.), *Essential papers on addiction*. New York: University Press.

[39] Sonne, S.C., Back, S.E., Zuniga, C.D., Randall, C.L., & Brady, K.T. (2003). Gender differences in individuals with comorbid alcohol dependence and post-traumatic stress disorder. *The American Journal on Addictions, 12*(5), 412-423. doi: 10.1111/j.1521-0391.2003.tb00484.x.

[40] Sharkansky, E.J., Brief, D.J., Peirce, J.M., Meehan, J.C., & Mannix, L.M. (1999). Substance abuse patients with posttraumatic stress disorder (PTSD): Identifying specific triggers of substance use and their associations with PTSD symptoms. *Psychology of Addictive Behaviors, 13*(2), 89-97. doi: 10.1037/0893-164X.13.2.89.

[41] Stewart, S.H., Conrod, P.J., Pihl, R.O., & Dongier, M. (1999). Relations between posttraumatic stress symptom dimensions and substance dependence in a community-recruited sample of substance-abusing women. *Psychology of Addictive Behavior, 13*(2), 78-88. doi: 10.1037/0893-164X.13.2.78.

[42] Stewart, S.H., Conrod, P.J., Samoluk, S.B., Pihl, R.O., & Dongier, M. (2000). Posttraumatic stress disorder symptoms and situation-specific drinking in women substance abusers. *Alcoholism Treatment Quarterly, 18*(3), 31-47. doi: 10.1300/J020v18n03_04.

[43] American Psychological Association. (2000). *Encyclopedia of Psychology (Vols 1-8)*. Retrieved from **http://www.apa.org/topics/depress/index.aspx**

[44] BC Society of Transition Housing. (2011). *Report on violence against women, mental health, and substance use.* Retrieved from **http://www.bcsth.ca/sites/default/files/BCSTH%20CWF%20Report_Final_2011.pdf**

[45] Bergman, B., Larsson, G., Brismar, B., & Klang, M. (1987). Psychiatric morbidity and personality characteristics of battered women. *Acta Psychiatrica Scandinavica, 76*(6), 678-683. doi: 10.1111/j.1600-0447.1987.tb02939.x.

[46] Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132. doi: 10.1023/A:1022079418229.

[47] Cory, J., Godard, L., Abi-Jaoude, A., & Wallace, L. (2010). *Building bridges: Linking women abuse, substance use, and mental ill health.* Retrieved from **http://www.bcwomens.ca/NR/rdonlyres/C1AA97BC-FAAB-40E9-972D-F377EE729080/45188/BB_summaryreport.pdf**

[48] Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132. doi: 10.1023/A:1022079418229.

[49] Campbell, R., Sullivan, C.M., & Davidson II, W.S. (1995). Women who use domestic violence shelters: Changes in depression over time. *Psychology of Women Quarterly, 19*(2), 237-255. DOI: 10.1111/j.1471-6402.1995.tb00290.x.

[50] Silva, C., McFarlane, J., Soeken, K., Parker, B., & Reel, S. (1997). Symptoms of post-traumatic stress disorder in abused women in a primary care setting. *Journal of Women's Health, 6*(5), 543-552. doi:10.1089/jwh.1997.6.543.

[51] Anderson, D.K., Saunders, D.G., Yoshihama, M., Bybee, D.I., & Sullivan, C.M. (2003). Long-term trends in depression among women separated from abusive partners. *Violence Against Women, 9*(7), 807-838. doi: 10.1177/1077801203009007004.

[52] Counts, D.A. (1987). Female suicide and wife abuse: A cross cultural perspective. *Suicide and Life-Threatening Behavior, 17*(3), 194-204. doi: 10.1111/j.1943-278X.1987.tb00267.x.

[53] Wingood, G.M., DiClemente, R.J., & Raj, A. (2000). Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. *American Journal of Preventive Medicine, 19*(4), 270-275. doi: 10.1016/S0749-3797(00)00228-2.

[54] Ackerson, L.K., Kawachi, I., Barbeau, E.M., & Subramanian, S.V. (2007). Exposure to domestic violence associated with adult smoking in India: A population-based study. *Tobacco Control, 16*(6), 378-383. doi: 10.1136/tc.2007.020651.

[55] Greaves, L., Poole, N., Okoli, C.T.C., Hemsing, N., Qu, A., Bialystok, L., et al. (2011). *Expecting to Quit: A Best-Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women (2nd Ed.).* Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Retrieved from **http://expectingtoquit.ca/documents/expecting-to-quit-singlepages.pdf**

[56] Wingood, G.M., DiClemente, R.J., & Raj, A. (2000). Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. *American Journal of Preventive Medicine, 19*(4), 270-275. doi: 10.1016/S0749-3797(00)00228-2.

[57] Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., et al. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *The Journal of the American Medical Association, 306*(5), 513-521. doi: 10.1001/jama.2011.1098.

[58] Gatz, M., Russell, L.A., Grady, J., Kram-Fernandez, D., Clark, C., & Marshall, B. (2005). Women's recollections of victimization, psychological problems, and substance use. *Journal of Community Psychology, 33*(4), 479-493. doi: 10.1002/jcop.20064.

[59] Parkes, T., Welch, C., Besla, K., Leavitt, S., Ziegler, M., MacDougall, A., et al. (2007). *Freedom from violence: Tools for working with trauma, mental health, and substance use.* Retrieved from **http://www.endingviolence.org/node/459**

[60] Gilbert, L., El-Bassel, N., Rajah, V., Foleno, A., Fontdevila, J., Frye, V., & Richman, B.L. (2000). The converging epidemics of mood-altering-drug use, HIV, HCV, and partner violence: A conundrum for methadone maintenance treatment. *The Mount Sinai Journal of Medicine, 67*(5-6), 452-464.

[61] Golinelli, D., Longshore, D.L., & Wenzel, S.L. (2009). Substance use and intimate partner violence: Clarifying the relevance of women's use and partners' use. *The Journal of Behavioral Health Services and Research, 36*(2), 199-211. doi: 10.1007/s11414-008-9114-6.

[62] Brookoff, D., O'Brien, K.K., Cook, C.S., Thompson, T.D., & Williams, C. (1997). Characteristics of participants in domestic violence: Assessment at the scene of domestic assault. *The Journal of the American Medical Association, 277*(17), 1369-1373. doi: 10.1001/jama.1997.03540410047029.

[63] Fals-Stewart, W., Golden, J., & Schumacher, J.A. (2003). Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addictive Behaviors, 28*(9), 1555-1574. doi: 10.1016/j.addbeh.2003.08.035.

[64] Kyriacou, D.N., Anglin, D., Taliaferro, E., Stone, S., Tubb, T., Linden, J.A., et al. (1999). Risk factors for injury to women from domestic violence. *The New England Journal of Medicine, 341,* 1892-1898. doi: 10.1056/NEJM199912163412505.

[65] Smith, P.H., Homish, G.G., Leonard, K.E., & Cornelius, J.R. (2011). Intimate partner violence and specific substance use disorders: Findings from the national epidemiologic survey on alcohol and related conditions. *Psychology of Addictive Behaviors,* ePub, No Pagination Specified. doi: 10.1037/a0024855.

[66] Stark, E.D., & Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health.* California: Sage Publications.

[67] Ontario Domestic Violence Death Review Committee. (2009). *Annual report to the chief coroner.* Toronto, ON: Office of the Chief Coroner. Retrieved from **http://www.crvawc.ca/documents/DVDRC2010.pdf**

[68] Ontario Domestic Violence Death Review Committee. (2010). *Annual report to the chief coroner.* Toronto, ON: Office of the Chief Coroner. Retrieved from **http://www.crvawc.ca/documents/2010report.pdf**

[69] Graham, K., Plant, M., & Plant, M. (2004). Alcohol, gender and partner aggression: A general population study of British adults. *Addiction Research and Theory, 12*(4), 385-401. doi: 10.1080/16066350410001717165.

[70] Friedman, S.H., & Loue, S. (2006). Incidence and prevalence of intimate partner violence by and against women with severe mental illness. *Journal of Women's Health, 16*(4), 471-480. doi: 10.1089/jwh.2006.0115.

[71] Carmen, E.H., Rieker, P.P., & Mills, T. (1984). Victims of violence and psychiatric illness. *The American Journal of Psychiatry, 141*(3), 378-383.

[72] Cascardi, M., Mueser, K.T., DeGiraloma, J., & Murrin, M. (1996). Physical aggression against psychiatric inpatients by family members and partners. *Psychiatric Services, 47*(5), 531-533.

[73] Warshaw, C., Brashler, P., & Gil, J. (2009). Mental health consequences of intimate partner violence. In C. Mitchell & D. Anglin (Eds.) *Intimate partner violence: A health-based perspective.* New York: Oxford University Press.

[74] Becker, K.D., Stuwig, J., & McCloskey, L.A. (2010). Traumatic stress symptoms of women exposed to different forms of childhood victimization and intimate partner violence. *Journal of Interpersonal Violence, 25*(9), 1699-1715. doi: 10.1177/0886260509354578.

[75] Koopman, C., Ismailji, T., Palesh, O., Gore-Felton, C., Narayanan, A., Saltzman, K.M., et al. (2007). Relationships of depression to child and adult abuse and bodily pain among women who have experienced intimate partner violence. *Journal of Interpersonal Violence, 22*(4), 438-455. doi: 10.1177/0886260506297028.

[76] Robertiello, G. (2006). Common mental health correlates of domestic violence. *Brief Treatment and Crisis Intervention, 6*(2), 111-121. doi: 10.1093/brief-treatment/mhj008.

[77] Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132. doi: 10.1023/A:1022079418229.

[78] Ford-Gilboe, M., Wuest, J., Varcoe, C., & Merritt-Gray, M. (2006). Translating research: Developing an evidence-based health advocacy intervention for women who have left abusive partners. *Canadian Journal of Nursing Research, 38*(1), 147-167.

[79] Statistics Canada. (1993). *The violence against women survey,* The Daily, November 18, 1993. (Catalogue no. 11001E).

[80] Hobbins, D. (2004). Survivors of childhood sexual abuse: Implications for perinatal nursing care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 33*(4), 485-497. doi: 10.1177/0884217504266908.

[81] Neggers, Y., Goldenberg, R., Cliver, S., & Hauth, J. (2004). Effects of domestic violence on preterm birth and low birth weight. *Acta Obstetricia et Gynecologica Scandinavica, 83*(5), 455–460. doi: 10.1111/j.0001-6349.2004.00458.x.

[82] Cohen, M.M., Schei, B., Ansara, D., Gallop, R., Stuckless, N., & Stewart, D.E. (2002). A history of personal violence and postpartum depression: Is there a link? *Archives of Women's Mental Health, 4*(3), 83-92. doi: 10.1007/s007370200004.

[83] Martine, S.L., Li, Y., Casanueva, C., Harris-Britt, A., Kupper, L.L., & Cloutier, S. (2006). Intimate partner violence and women's depression before and during pregnancy. *Violence Against Women, 12*(3), 221-239. doi: 10.1177/1077801205285106.

[84] Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect, 32*(8), 797-810. doi: 10.1016/j.chiabu.2008.02.004.

[85] Kilpatrick, K.L., Litt, M., & Williams, L.M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry, 67*(4), 639-644. doi: 10.1037/h0080261.

[86] Berry, D.B. (1998). *The domestic violence sourcebook.* Los Angeles, CA: Lowell House.

[87] Tajima, E.A. (2004). Correlates of the co-occurrence of wife abuse and child abuse among a representative sample. *Journal of Family Violence, 19*(6), 391-402. doi: 10.1007/s10896-004-0684-7.

[88] Levendosky, A.A., Huth-Bocks, A., & Semel, M.A. (2002). Adolescent peer relationships and mental health functioning in families with domestic violence. *Journal of Clinical Child & Adolescent Psychology, 31*(2), 206-218. doi: 10.1207/S15374424JCCP3102_06.

[89] *Child and Family Services Act R.S.O. 1990 Chapter C. 11* (On) s. 2.f (i) (ii) (iii) (iv) (v) (Can).

[90] Buckner, J.C., Beardslee, W.R., & Bassuk, E.L. (2004). Exposure to violence and low-income children's mental health: Direct, moderated, and mediated relations. *American Journal of Orthopsychiatry, 74*(4), 413-423. doi: 10.1037/0002-9432.74.4.413.

[91] Edleson, J.L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*(8), 839-870. doi: 10.1177/088626099014008004

[92] Cummings, J.G., Pepler, D.J., & Moore, T.E. (1999). Behavior problems in children exposed to wife abuse: Gender differences. *Journal of Family Violence, 14*(20), 133-156. doi: 10.1023/A:1022024702299

[93] Baker, L.L., & Jaffe, P.G. (2007). *Woman abuse affects our children: An educator's guide.* Toronto, ON: Ontario Women's Directorate. Retrieved from **http://www.cpco.on.ca/ProfessionalDevelopment/documents/WomanAbuse.pdf**

[94] Mullender, A., Hague, G., Imam, U.F., Kelly, L., Malos, E., & Regan, L. (2002). *Children's perspectives on domestic violence.* London: Sage.

[95] Cunningham, A., & Baker, L. (2007). Little Eyes, Little Ears. How violence against a mother shapes children as they grow. Ottawa, ON: The Centre for Children and Families in the Justice System. Retrieved from **http://www.lfcc.on.ca/little_eyes_little_ears.pdf**

[96] Sagrestano, L.M., Caroll, D., Rodriguez, A.C., & Nuwayhid, B. (2004). Demographic, psychological, and relationship factors in domestic violence during pregnancy in a sample of low-income women of colour. *Psychology of Women Quarterly, 28*(4), 309-322. doi: 10.1111/j.1471-6402.2004.00148.x.

[97] Cunningham, A., & Baker, L. (2007). Little Eyes, Little Ears. How violence against a mother shapes children as they grow. Ottawa, ON: The Centre for Children and Families in the Justice System. Retrieved from **http://www.lfcc.on.ca/little_eyes_little_ears.pdf**

[98] Levendosky, A.A., & Graham-Bermann S. A. (2001). Parenting in battered women: The effects of domestic violence on women and their children. *Journal of Family Violence, 16*(2), 171-192. doi: 10.1023/A:1011111003373.

[99] McGuigan, W.M., Vuchinich, S., & Pratt, C.C. (2000). Domestic violence, parents' view of their infant, and risk for child abuse. *Journal of Family Psychology, 14*(4), 613-624. doi: 10.1037/0893-3200.14.4.613.

[100] Coohey, C. (2007). The relationship between mothers' social networks and severe domestic violence: A test of the social isolation hypothesis. *Violence and Victims, 22*(4), 503-512. doi: 10.1891/088667007781554008.

[101] Martins, C., & Gaffan, E.A. (2000). Effects of early maternal depression on patterns of infant-mother attachment: A meta-analytic investigation. *Journal of Child Psychology and Psychiatry, 41*(6), 737-746. doi: 10.1111/1469-7610.00661.

[102] Dubowitz, H., Black, M.M., Kerr, M.A., Hussey, J.M., Morrel, T.M., Everson, M.D., et al. (2001). Type and timing of mothers' victimization: Effects on mothers and children. *Pediatrics, 107*(4), 728-735.

[103] Hanington, L., Heron, J., Stein, A., & Ramchandani, P. (2011). Parental depression and child outcomes – is marital conflict the missing link? *Child: Care, Health, and Development (early view).* doi: 10.1111/j.1365-2214.2011.01270.x. Retrieved from **http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2214.2011.01270.x/pdf**

[104] Cummings, E.M., Keller, P.S., & Davies, P.T. (2005). Towards a family process model of maternal and paternal depressive symptoms: Exploring multiple relations with child and family functioning. *Journal of Child Psychology and Psychiatry, 46*(5), 479-489. doi: 10.1111/j.1469-7610.2004.00368.x.

[105] Jordan, J.V., & Hartling, L.M. (2002). New developments in relational-cultural theory. In M. Ballou & L.S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives.* New York, NY: The Guilford Press.

[106] Banks, A. (2006). Relational therapy for trauma. *Journal of Trauma Practice, 5*(1), 25-47. doi: 10.1300/J189v05n01_03.

[107] Chemtob, C., & Carlson, J.G. (2004). Psychological effects of domestic violence on children and their mothers. *International Journal of Stress Management, 11*(3), 209-226. doi: 10.1037/1072-5245.11.3.209.

[108] Schreier, A., Wittchen, H-U., Höfler, M., & Lieb, R. (2008). Anxiety disorders in mothers and their children: Results from a prospective longitudinal community study. *The British Journal of Psychiatry, 192*, 308-309. doi: 10.1192/bjp.bp.106.033589.

[109] Beidel, D.C., & Turner, S.M. (1997). At risk for anxiety: I. Psycholopathology in the offspring of anxious parents. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(7), 918-924. doi: 10.1097/00004583-199707000-00013.

[110] Halligan, S.L., Murray, L., Martins, C., & Cooper, P.J. (2006). Maternal depression and psychiatric outcomes in adolescent offspring: A 13-year longitudinal study. *Journal of Affective Disorders, 97*(1-3), 145-154. doi: 10.1016/j.jad.2006.06.010.

[111] Landi, N., Montoya, J., Kober, H., Rutherford, H.J., Mencl, W.E., Worhunsky, P.D., et al. (2011). Maternal neural responses to infant cries and faces: Relationships with substance use. *Frontiers in Psychiatry, 2*(32), No Pagination Specified. doi: 10.3389/fpsyt.2011.00032.

[112] Frank, D.A., Augustyn, M., Kinght, W.G., Pell, T., & Zuckerman, B. (2001). Growth, development, and behavior in early childhood following prenatal cocaine exposure. *The Journal of the American Medical Association, 285*(12), 1613-1625. doi: 10.1001/jama.285.12.1613

[113] Johnson, J.L., & Leff, M. (1999). Children of substance abusers: Overview of research findings. *Pediatrics, 103*(Suppl 2), 1085-1099.

[114] Rydelius, A. (1997). Annotation: Are children of alcoholics a clinical concern for child and adolescent psychiatrists of today? *The Journal of Child Psychology and Psychiatry, 38*(6), 615-624. doi: 10.1111/j.1469-7610.1997.tb01688.x

[115] Trocme, N., MacLaurin, B., Fallon, B., Daciuk, J., Billinglsey, D., Tourigny, M., et al. (2001). *Canadian incidence study of reported child abuse and neglect (CIS): Final report.* Ottawa, ON: Minister of Public Works and Government Services Canada. Retrieved from **http://www.phac-aspc.gc.ca/publicat/cisfr-ecirf/pdf/cis_e.pdf**

[116] Walsh, C., MacMillan, H., & Jamieson, E. (2002). The relationship between parental psychiatric disorder and child physical and sexual abuse: Findings from the Ontario Health Supplement. *Child Abuse & Neglect, 26*(1), 11-22. doi: 10.1016/S0145-2134(01)00308-8.

[117] Hughes, H.M., Graham-Bermann, S.A., & Gruber, G. (2001). Resilience in children exposed to domestic violence. In S.A. Graham-Bermann & J.L. Edleson (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 67-90). Washington, DC: American Psychological Association.

[118] Martinez-Torteya, C., Bogat, G.A., Von Eye, A., & Levendosky, A.A. (2009). Resilience among children exposed to domestic violence: The role of risk and protective factors. *Child Development, 80*(2), 562-577. doi: 10.1111/j.1467-8624.2009.01279.x.

[119] Graham-Bermann, S.A., Gruber, G., Howell, K.H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV). *Child Abuse Neglect, 33*(9), 648-660. doi: 10.1016/j.chiabu.2009.01.002.

[120] Graham-Bermann, S.A., Gruber, G., Howell, K.H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV). *Child Abuse Neglect, 33*(9), 648-660. doi: 10.1016/j.chiabu.2009.01.002.

[121] Jaffe, P.G., Baker, L.L., & Cunningham, A. J. (Eds.). (2004). *Protecting children from domestic violence: Strategies for community intervention.* New York: The Guilford Press.

[122] Nicholson, J., & Henry, A.D. (2003). Achieving the goal of evidence-based psychiatric rehabilitation practices for mothers with mental illnesses. *Psychiatric Rehabilitation Journal, 27*(2), 122-130.

[123] Poole, N., & Dell, C.A. (2005). Girls, women and substance use. Retrieved from **http://www.ccsa.ca/2005%20CCSA%20Documents/ccsa-011142-2005.pdf**

[124] Greaves, L., Pederson, A., Varcoe, C., Poole, N., Morrow, M., Johnson, J., & Irwin, L. (2004). Mothering under duress: Women caught in a web of discourses. *Journal of the Association for Research on Mothers, 6*(1), 16-27.

[125] Miotto, K.A., Suti, E., Hernandez, M.M., & Pham, P.L. (2006). Pregnancy and substance abuse. In V. Hendrick (Ed.), *Psychiatric disorders in pregnancy and the postpartum: Principles and treatment* (pp. 153-178). Totowa, New Jersey: Humana Press.

[126] Beckman, L. (1994). Treatment needs of women with alcohol problems. *Alcohol, Health and Research World, 18*(3), 206-211.

[127] Zelman, A.B. (Ed.). (1996). *Early intervention with high-risk children: Freeing prisoners of circumstance.* Northvale, New Jersey: Jason Aronson Inc.

[128] Finkelstein, N., Kennedy, C., Thomas, K., & Kearns, M. (1997). *Gender-specific substance abuse treatment.* Alexandria, VA: National Women's Resource Center for the Prevention and Treatment of Alcohol, Tobacco, and Other Drug Abuse and Mental Illness.

[129] Nicholson, J., & Henry, A.D. (2003). Achieving the goal of evidence-based psychiatric rehabilitation practices for mothers with mental illnesses. *Psychiatric Rehabilitation Journal, 27*(2), 122-130

Appendix 3-1

Literature Review Summary

During the period of January 4th – 11th 2010, we conducted a systematic literature search examining treatment and training for professionals working with women survivors of DV who also experience substance use and/or mental health problems. This search was conducted through a Social Sciences database, Scholars Portal. The search was limited to English articles between the years 2005-2010. Our search terms are as follows: domestic violence, intimate partner violence, intimate partner abuse, spousal abuse, marital violence, violence against women, mental health, addiction, substance abuse, treatment, treatment modalities, trauma informed, education, curriculum, and training. This generated a total of 3,484 results. Exclusion criteria were: men, perpetrators, child/adolescent/teen, and couples. We also excluded books from our review. In total, 37 articles were identified for review. Of these, we excluded 6 dissertations; 4 articles about perpetrators; 1 because it did not look at DV; 2 because they did not look at either mental health or substance abuse; and 3 because they were irrelevant. Our literature review is based on 21 articles that were relevant to our topic. In total, 14 examined the intersections between DV, mental health, and substance use, 7 examined the relationships between DV and substance use (none looked at DV and mental health). The literature suggests that there is a need for integrated, trauma-informed care for workers in these sectors, although there is very little concrete information about what specifically these workers should know or skills they should have. Despite the call for this type of treatment for these overlapping issues, there is little to draw from to create a curriculum.

During the period of October – November 2011, we conducted a literature search examining treatment and training for women survivors of DV who also experience substance use and/or mental health problems in DV shelters. The search was conducted through two databases: the International Bibliography of the Social Sciences (IBSS) and the Gender Studies Database (GSD). Our search terms are as follows: domestic violence, intimate partner violence, intimate partner abuse, spousal abuse, marital violence, violence against women, mental health, addiction, substance abuse, treatment, and shelter. This generated 109 results from the IBSS database and 33 results from the GSD, for a total of 142 results. 107 articles were excluded for the following reasons: did not mention 'shelter' in either title or abstract (84); duplicate (17); dissertation (4); not specific to DV shelters (1); and no treatment (1). 33 articles were included for review. Of these, 31 were excluded for the following reasons: no mental health and/or substance use (30); not specific to DV shelters (2); and not specifically about shelters but about all DV services (1). Our literature review is based on 2 articles that were relevant to our topic. Both articles examined the relationships between DV and substance use for women in DV shelters. Both studies suggest that DV shelters may be a good place to address women's substance use. However, the paucity of literature on treatment for women experiencing DV as well as mental health and/or substance use issues in DV shelters leaves very little to draw from to create a curriculum.

Appendix 3-2

Prevalent Mental Health Problems Related to the Experience of DV

Anxiety Disorders

In addition to PTSD there are several other types of anxiety disorders:[1]

Type	Patterns
Generalized Anxiety Disorder (GAD)	Excessive anxiety and worry about a number of events or activities occurring for more days than not over a period of at least 6 months with associated symptoms (such as fatigue and poor concentration).
Specific Phobia	Marked and persistent fear of clearly discernible objects or situations (such as flying, heights and animals).
Social Phobia, also known as Social Anxiety Disorder	Exposure to social or performance situations almost invariably provokes an immediate anxiety response that may include palpitations, tremors, sweating, gastrointestinal discomfort, diarrhea, muscle tension, blushing or confusion, and which may meet criteria for panic attack in severe cases.
Obsessive-Compulsive Disorder	***Obsessions:*** Persistent thoughts, ideas, impulses or images that are intrusive and inappropriate and that cause marked anxiety or distress. Individuals with obsessions usually attempt to ignore or suppress such thoughts or impulses or to counteract them by other thoughts or actions (compulsions). ***Compulsions:*** Repetitive behaviours (such as hand washing, ordering or checking) or mental acts (such as praying, counting or repeating words) that occur in response to an obsession or occur in a ritualistic way.
Panic Disorder	Presence of recurrent, unexpected panic attacks, followed by at least 1 month of persistent concern about having additional attacks, worry about the implication of the attack or its consequences, or a significant change in behaviour related to the attacks. There are three clusters of symptoms: re-experiencing, avoidance and numbing, and arousal. Panic disorders are sometimes associated with agoraphobia - anxiety about, or the avoidance of, places or situations from which escape might be difficult or embarrassing, or in which help may not be available in the event of a panic attack or panic-like symptoms. The essential feature of the panic attack is a discrete period of intense fear or discomfort that is accompanied by at least 4 of 13 physical symptoms, such as: • Palpitations, increased heart rate or pounding heart • Sweating • Trembling or shaking • Sensations of shortness of breath or smothering • Feeling of choking • Chest pain or discomfort • Nausea or abdominal distress • Dizziness, unsteadiness, light-headedness or fainting • De-realization or de-personalization • Fear of losing control or going crazy • Fear of dying • Paresthesias (numbness or tingling sensation) • Chills or hot flashes

Dissociative Disorders

People who have experienced painful, traumatic events such as violence, abuse and/or neglect in childhood may be particularly at risk for developing a dissociative disorder. One study found that 46% of people with a dissociative disorder experienced physical abuse in childhood, and 33% indicated that they had been sexually abused as a child. An individual may develop a dissociative disorder as a way of escaping the trauma, which may be too difficult to confront or cope with.

There are several types of dissociative disorders, all of which cause a change in consciousness, memory, identity, or how a woman views her surroundings. This change can come on abruptly or slowly, and it may not happen all the time. There are five types of dissociative disorders:[2]

Type	Patterns
Dissociative Amnesia	A person has one or more experiences of being unable to remember or recall important information about himself associated with some type of traumatic or stressful event.
Dissociative Fugue	Sudden forgetting one's past or experiencing some confusion about one's identity or even assuming a completely new identity.
Dissociative Identity Disorder	Once called, "Multiple Personality Disorder." A person with dissociative identity disorder will have two or more separate identities that each have their own way of thinking and relating to the world.
Depersonalization Disorder	Feeling "detached from" one's thoughts or body. Despite these experiences though, the person still stays in touch with reality.
Dissociative Disorder Not Otherwise Specified	This term is used by the DSM-IV to describe a dissociative disorder where the main feature is still some kind of dissociative experience, but criteria for other dissociative disorders are not present.

Eating Disorders

Eating disorders involve a serious disturbance in eating behaviour – either eating too much or too little. Unhealthy eating patterns that "take on a life of their own." The voluntary eating of smaller or larger portions of food than usual is common, but for some people this develops into a compulsion and the eating behaviours become extreme. There are three types of eating disorders:[3]

Type	Patterns
Anorexia nervosa	Refusal to maintain a minimally normal body weight, carry an intense fear of gaining weight and have a distorted perception of the shape or size of their bodies.
Bulimia nervosa	Binge eating and then use compensatory methods to prevent weight gain, such as induced vomiting, excessive exercise or laxative abuse. They also place excessive importance on body shape and weight. In order for a diagnosis of bulimia nervosa to be made, the binge eating and compensatory behaviours must occur, on average, at least twice a week for 3 months.
Binge eating disorder (BED)	Binge eating is not followed by some compensatory behaviour, such as vomiting, excessive exercise or laxative abuse. This disorder is often associated with obesity.

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[1] American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

[2] American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

[3] American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Appendix 3-3

Inventory of Some Commonly Abused Illicit and Licit Drugs[1]

Substances: Category and Name	Examples of Commercial & Street Names	Acute Effects/Health Risks
Tobacco		
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Increased blood pressure, and heart rate/chronic lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction
Alcohol		
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness/increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose
Cannabinoids		
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis/cough, frequent respiratory infections; possible mental health decline; addiction
Hashish	Boom, gangster, hash, hash oil, hemp	
Opioids & Morphine Derivatives		
Heroin	*Diacetylmorphine:* smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	Pain relief; euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; drowsiness/slowed or arrested breathing; unconsciousness; constipation; endocarditis; hepatitis; HIV; coma; tolerance; addiction; fatal overdose ***Also, for codeine*** - less analgesia, sedation, and respiratory depression than morphine
Opium	*Laudanum, paregoric:* big O, black stuff, block, gum, hop	
Codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine;* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	
Fentanyl	*Actiq, Duragesic, Sublimaze;* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	

Substances: Category and Name	Examples of Commercial & Street Names	Acute Effects/Health Risks
Opioids & Morphine Derivatives (con't)		
Morphine	*Roxanol, Duramorph;* M, Miss Emma, monkey, white stuff	Pain relief; euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; drowsiness/slowed or arrested breathing; unconsciousness; constipation; endocarditis; hepatitis; HIV; coma; tolerance; addiction; fatal overdose
Other opioid pain relievers (oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene)	Tylox, OxyContin, Percodan, Percocet; oxy 80s, oxycotton, oxycet, hillbilly heroin, percs, Demerol, meperidine hydrochloride; demmies, pain killer Dilaudid; juice, dillies Vicodin, Lortab, Lorcet; Darvon, Darvocet	
Stimulants		
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness/rapid or irregular heart beat; heart failure, tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behavior; psychosis/weight loss, insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction ***Also, for cocaine*** - nasal damage from snorting, increased temperature/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition ***Also, for amphetamines*** - rapid breathing; hallucinations/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction ***Also, for methamphetamine*** - severe dental problems, rapid breathing; hallucinations/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction ***Also, for methylphenidate*** - increase or decrease in blood pressure, psychotic episodes/digestive problems, loss of appetite, weight loss
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	
Methylphenidate	*Ritalin;* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	
Depressants		
Barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital;* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	Reduced pain and anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration/ confusion, fatigue; impaired coordination, memory, judgment; respiratory depression and arrest, addiction ***Also, for barbiturates*** - sedation, drowsiness/ depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness ***Also, for benzodiazepines*** - sedation, drowsiness/ dizziness ***Also, for flunitrazepam*** - visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects
Benzodiazepines (other than flunitrazepam)	Ativan, Halcion, Librium, Valium, Xanax; candy, downers, sleeping pills, tranks	
Flunitrazepam	*Rohypnol;* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	

Substances: Category and Name	Examples of Commercial & Street Names	Acute Effects/Health Risks
Club Drugs		
MDMA (methylenedioxy-methamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	Mild hallucinogenic effects; increased tactile sensitivity; empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping/sleep disturbances; depression; impaired memory; hyperthermia; addiction
Flunitrazepam	*Rohypnol:* forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	Sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination/addiction
GHB	*Gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	Drowsiness; nausea; headache; disorientation; loss of coordination; memory loss/unconsciousness; seizures; coma
Dissociative Drugs		
Ketamine	*Ketalar SV:* cat Valium, K, Special K, vitamin K	Feelings of being separate from one's body and environment; impaired motor function/anxiety; tremors; numbness; memory loss; nausea ***Also, for ketamine*** - analgesia; impaired memory; delirium; respiratory depression and arrest; death ***Also, for PCP and analogs*** - analgesia; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations **Also, for DXM** - euphoria; slurred speech; confusion; dizziness; distorted visual perceptions
PCP and analogs	*Phencyclidine:* angel dust, boat, hog, love boat, peace pill	
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	
Dextromethorphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	
Hallucinogens		
LSD	*Lysergic acid diethylamide:* acid, blotter, cubes, microdot yellow sunshine, blue heaven	Altered states of perception and feeling; hallucinations; nausea ***Also, LSD and mescaline*** - increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness, dizziness, weakness, tremors; impulsive behavior; rapid shifts in emotion ***Also, for LSD*** - Flashbacks, Hallucinogen Persisting Perception Disorder **Also for psilocybin** - nervousness; paranoia; panic
Mescaline	Buttons, cactus, mesc, peyote	
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	
Other Compounds		
Anabolic steroids	Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: roids, juice, gym candy, pumpers	No intoxication effects/hypertension; blood clotting and cholesterol changes; liver cysts; hostility and aggression; acne; in adolescents—premature stoppage of growth; in males—prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females—menstrual irregularities, development of beard and other masculine characteristics
Inhalants	Solvents (paint thinners, gasoline, glues); gases (butane, propane, aerosol propellants, nitrous oxide); nitrites (isoamyl, isobutyl, cyclohexyl): laughing gas, poppers, snappers, whippets	Varies by chemical - stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing/cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death

[1] National Institute on Drug Abuse. (2010). *Commonly abused drugs.* Retrieved from **http://www.drugabuse.gov/DrugPages/DrugsofAbuse.html**.

SECTION FOUR: **BUT WHAT DO I DO?**

A lot of us, from schooling and different workshops, we know the description of what an addiction looks like and what signs to watch for or, you know, what depression means and all that kind of thing, but what we're looking for is more practical, you know, hands-on techniques… How do you approach someone without offending them about these topics?… work with them on a daily basis?… get through the counselling.

(SHELTER FOCUS GROUP)

I think one of the things to do right at the beginning is realize that this is not about doing things for someone, but supporting the client in whatever way so she can figure out how to do what she needs to do for herself. And that's why those first questions that you ask – if there's any judgment in them at all, you close the door. There's a real art to asking questions… Maybe you don't need to have the expertise to know whether you're dealing with a mental health issue, or a legal issue, or addiction. Maybe what you need is the expertise to ask the kinds of questions of the victim that helps HER figure out what's the most important thing that she needs to do for herself – right now.

(ROUND TABLE PARTICIPANT, RENFREW, ONTARIO)

In this section some concrete tools and strategies to address co-occurring DV, mental health and/or substance use problems are presented. The goal of this section is not to turn anyone into an expert on all three issues but to provide interventions, tools and techniques that may help in day-to-day practice. Those who work with women bring to their work a range of expertise and experience, much of this knowledge can be applied to supporting women who experience complex problems. However, "I'm afraid of saying the wrong thing – of making things worse, of precipitating a crisis" a number of frontline workers told us during the round tables and pilot test workshops. It is likely therefore, that some information in this section may be new; it is our hope it will also prove useful.

In the following pages we first review some basic counselling principles and strategies then consider ways of asking and responding to disclosures of DV; ways of asking and responding to disclosures of mental health problems; and, ways of asking and responding to disclosures of substance use. In each section, there is an emphasis on concrete tools including examples of how to frame questions, helpful responses, and what to do in the event of a crisis. Naturally the piece on DV is likely to be most useful to those with little experience of violence against women and considerations of safety in the face of imminent danger. Similarly, those focused on mental health and substance use will likely be most useful to those with less experience of these problems and related issues such as dissociation, suicide risk and harm reduction strategies. The section concludes with a review of the stages of change model, a discussion of situations of nondisclosure, and what to do when children are at risk.

Why ask about DV in a substance treatment or mental health counselling centre? Why ask about substance use in a VAW shelter? Why learn about trauma? Clearly, the more that is known about the complex problems a woman is struggling with, the greater the likelihood that the appropriate interventions and referrals are offered. Where an organization or agency is unable to provide the appropriate service, asking specific questions can help identify the resources and referrals that will better meet her needs. Knowing more about her and what has happened to her will

also help offset frustration if she is unable to follow through on suggestions, fails to keep appointments, or reneges on commitments. Knowing more will help those she is working with to more effectively advocate on her behalf. And perhaps most importantly, information shared in response to specific questions may be critical in developing plans for her safety. Finally, asking questions can be an important intervention, helping her to recognize or acknowledge the circumstances of her reality.

It is also true that in some instances questions are asked in order to "screen women out" from treatment or service. Not surprisingly, such policies can result in women choosing to not disclose and therefore not receiving the full support they need.

ASKING ABOUT DV AND RESPONDING TO DV CRISES

General principles in counselling

As reviewed in other sections, the key principles of an effective intervention include being nonjudgmental, regarding her as the expert, helping her articulate what she needs, and remembering that she has strengths and resources that have enabled her to survive to this point in time.

Other general principles to follow when working with women with co-occurring problems include:

- Work from a woman-centred approach. Meet her where she is and work to understand her goals, then you can tailor the intervention to help her meet her goals.
- Focus on her strengths and assets instead of her deficits. For example, highlight her strength in coming forward for help and acknowledge her systems of support rather than what she does not, or believes she does not, have.
- Communicate in a manner that fosters trust and respect. This requires open and honest communication, compassion, and empathy. Use neutral language and avoid words like 'dirty', 'clean', substance abuse', 'batterer', 'abuser', etc. as they are stigmatizing and may leave a client feeling judged, criticized or misunderstood.
- Pay attention to your body language. Uncrossed arms and legs are more inviting and suggest your openness to hear her disclosure. Explain why you would like to take notes and ask her permission to do so. Make eye contact to reassure her that you are still listening and are interested in what she is saying. Maintain a warm, inviting presence and remember that this is not easy for her.
- Discuss your agency's confidentially policy; there may be limitations to confidentiality that she needs to be aware of including your obligations and duty to report high risk self-harm, danger to 3rd parties, or child safety concerns.
- Let the client have some control over the process. It is important that she feels safe and comfortable. Let her know that if she needs a break she should let you know. You could say:

  "I want to make this process as comfortable as possible for you. If I ask anything that makes you feel uncomfortable or you don't want to answer it right now, let me know and we could talk about it another time. If you feel you would like a break, that's also ok, just let me know. I'll do my best to check in with you to see how you are doing. Does that sound ok to you?"
- Begin the interview with the least sensitive topic and then gradually move on to more difficult topics. This allows time for rapport and trust to develop. You could say:

  "Let's start by talking about your current situation. This will give me an opportunity to get to know you a little better and learn what's going on in your life at the moment. We'll discuss your general information first and then move on to discussing the reasons you are here and your goals for (your stay or our work together depending upon your location and role). Are you comfortable with that?"

To learn more about feminist counselling, visit the OAITH website for the video, Feminist Anti-Violence Counselling at: **http://www.oaith.ca/resources/videos.html**

Documentation and record keeping

Before committing to paper information about a client's mental health or substance use, consider whether or not a written record of this information is likely to be helpful or harmful to her in the future. Records can be subpoenaed and used to discredit or undermine her child custody application or criminal court proceedings. What are the benefits of recording information she discloses about her mental health status or substance use? What negative impacts might result from documenting this information? Is this information useful and directly relevant to the work the woman is doing with this agency/me? Of course, if the organization or agency you work for has its own policies on documentation you must follow these, although you may wish to start a dialogue with other staff and managers on this topic.

Asking and Responding to Disclosures of DV

> *Our decisions are only as good as the information we base them on.*
> **(Robert Morris, Crown Attorney, Goderich ON)**

Many organizations that work with women believe they do not have the in-house expertise or staff time to adequately assess DV. However, adding questions to current intake forms or procedures can help staff identify when there is a problem that requires more in-depth consideration. More knowledge will help staff feel more comfortable with these discussions.

If asking about DV has not been a regular part of practice, front line workers may feel unsure about how to begin. It may help to know that in study after study women report they are not offended when asked direct questions about abuse when the questions are asked in a nonjudgmental way by an individual who is prepared to "hear" the response.[1] While there are a number of validated tools or screening instruments used in research studies, the purpose of asking about DV is to create the opportunity for the woman to disclose. This ensures a better understanding of her, her life context, and the possible connections between the presenting problem and the experience of abuse but perhaps most importantly it provides the necessary information to allow for appropriate safety planning. You might consider saying:

> *"Because violence is so common in women's lives and because there is help available for women who are hurt by their partners, I now ask every woman (or client) about domestic violence. Have you ever been hurt, physically or psychologically by your current or former partner?"*

If there is a positive response you will need to follow up with more specific questions. If the abuse was from a past partner, ask if she is still being threatened or at risk from this partner. Recent separation can be a high risk indicator for more serious or lethal violence. If the abuse is from a current partner, a risk assessment should be completed and appropriate plans for her safety developed.

Making the Connections between DV and Mental Health: Other Questions to Ask

- Many women say that abuse has had a greater impact on their mental health than on their physical being. Do you feel that your depression/anxiety/insomnia, fatigue (etc.) may be related to your experience of abuse?
- Has your medication ever made you more vulnerable to abuse?

Safety first

Thinking about her safety begins as soon as she discloses. She may be at risk simply because she has disclosed the abuse. Her partner may routinely interrogate her every time she talks to anyone. Her safety plan may start by having to hide the fact that she talked to anyone about the abuse or possibly that she saw anyone at all.

What you do next may depend upon the assessment of current risk. Without specific training, you may not be able to complete a formal risk assessment nevertheless you need to consider the following:

1. The pattern and history of abuse (how frequent, how severe, how recent, is there ongoing contact)
2. The level of immediate risk and potential lethality
3. Safety of the children
4. Her level of isolation or support

The important thing to keep in mind is that an abused woman is often skilled at anticipating the risks to herself and her children as she lives with this every day. She expends a great deal of energy trying to anticipate her partner's feelings, needs, and reactions, because her safety depends upon it. The starting point should always be with the woman as expert of her own situation. Nevertheless, we also know that approximately 45% of the women who experienced near lethal violence believed they were in no immediate danger.[2] Therefore, we cannot assume that she is always able to accurately assess the level of danger. Your role is to help her recognize the level of risk, support her skills, and enhance her knowledge about resources and options available to her, now or in the future.

To learn more about risk assessment and management, see: Domestic Violence Risk Assessment & Risk Management Strategies developed by the London Centre for Research and Education on Violence Against Women and Children.

Risk factors for lethality

The sixth Annual Report of the Domestic Violence Death Review Committee (2008) identified the top risk factors for lethality:

- Actual or pending separation
- History of domestic violence
- Perpetrator is depressed, not necessarily clinically diagnosed
- Obsessive behaviour of the perpetrator
- Escalation of violence
- Prior threats to kill the victim
- Prior threats to commit suicide
- Prior attempts to isolate the victim
- Access to and/or possession of firearms
- And when there are children, custody and access issues related to the separation

Take fears and increased violence seriously

Many abusers use the threat of harm or even death, as a way to control their partners. It is difficult to predict which abusers will follow through on these threats. Even abusers who have not used a great deal of physical violence in the past have gone on to kill their partners (ex-partners) and their children.

An abused woman is at most risk at the time of separation, when an abuser is losing control over her. In fact, a woman's reluctance to leave may be based on this reality. To decrease the risk associated with separation, plans may need to be well thought out. Many women indicate that it is in fact harder to monitor the risks to themselves and their children after separation, leaving them in a constant state of fear.

Do not minimize a woman's fears of increased violence or lethality.

Although the woman herself is the best person to know what an abuser is capable of, even she may not be able to predict what harm an abuser can do.

By making threats that they may or may not follow through on, the abuser succeeds in keeping a woman off balance and fearful all of the time. The best defense is to take all threats seriously while helping her to not become immobilized by fear.

Safety planning

Safety planning with a woman who is abused must include all dimensions of her life, where she lives, where she may be attending school or working, or during the children's access visits with the abuser. Whether a woman is with her abusive partner, planning on leaving, or already separated, you can assist her assess the risks and plan for her safety and the safety of her children.

1) **Safety planning starts where the woman is:**
   - Determine her current situation with her abusive partner – is she living with him, planning to leave, in a shelter, on her own.
   - Explore what safety means to her.
   - Ask her what she has done, or does now, to be safe from her partner.
   - Find out what she is most afraid of at this time.
   - Discuss what she finds most difficult when trying to be safe.
   - Ask her what she wants to do now.
   - Ask her if she has any long term plans.
   - Validate the things she does currently to stay safe.
   - Acknowledge the step she has taken in sharing information with you.

2) **Safety planning is about sharing information:**
   - Ensure that the woman knows about the 24 hour help line in her area. If she does not speak English, explore other options for getting assistance. If she is deaf, make sure the number she is given has TTY (teletype writer or text telephone).
   - Explore whether she knows about women's shelters, if she has ever been in one, and if she would consider going to a shelter at this time. Remember that many women will never consider going to a shelter. However, they may be comfortable talking to someone. Let them know that they don't have to stay at the local shelter, but they are welcome to call 24 hours a day, 7 days a week, to speak with someone who understands these situations.
   - Be sensitive to the fact that staying in a shelter can be very isolating for a woman who does not speak English, and be aware of shelters serving specific cultural/language needs. Similarly, know which shelters are accessible for women with disabilities, and which have a harm reduction approach. Consider visiting a shelter with her when she is not in crisis to help demystify what shelters look like.
   - Ask her what she knows about the legal system, and if she has had any contact with the police or a family lawyer.
   - Have a list of referrals that can assist women and their children – counsellors, group programs, interpreters, culturally specific services, gay and lesbian services, assistance for women with disabilities, programs for abusers.
   - If information is not known about a specific service or the service is not familiar, call the service and ask for more information. It may also be helpful to advocate for a woman, as it may be too intimidating for her to call on her own.
   - Be prepared to help her call the police in situations of imminent high-risk danger.

3) **Safety planning considers the present as well as the future:**
   - Help the abused woman to determine what resources she can make use of now, or in the near future. Is there a counselling centre in the community where she can talk to someone in more detail about her concerns?

- For women who are returning home to their abusive partners, talk about what she can say to him about where she has been or what she has said.
- Talk about a contingency plan, "What can she do if things get worse – if she has to leave the house suddenly?" or "Would she call the help line if she needed someone to talk to?" "Can she come up with a signal or code word to share with someone, when they would know to call the police?"
- Ask her to think about how she would get out quickly, and how she can avoid getting trapped in the house. Alert her to dangers of some rooms, eg. kitchens, during violent encounters.
- Has she discussed a safety plan with the children? Do they know how to call 911? Is there a safe neighbour they could go to and ask for help?
- If she is considering going to stay with a friend or family member, ask her if her abusive partner is likely to find her there, and how safe she would be.

4) Safety planning involves exploring the risks and benefits of different actions/strategies:

- Be clear that there is no perfect strategy that will protect her and her children, and she may need help to determine what will work best for her. A referral to a community counselling service or shelter that has expertise in this area can be helpful.
- Discuss the benefits of various strategies, such as the legal system, as well as the risks. Do not present calling the police, or going to the shelter as the end to all of her problems. She will know best how her partner might react to these strategies.
- Some actions are more risky than others, such as leaving her children, as she may not get them back. Caution her to get legal advice on custody and access issues from a lawyer experienced in VAW. When women do not get good advice they may agree to something the abuser suggests, only to find a situation has been created for ongoing harassment.
- Respect that she has developed her safety and survival strategies over time and with experience of the abuser. Recognize that she may have tried some of the suggestions being recommended and found they did not work for her. Some women have taken action through all of the legal and community resources available to them and still found it is safer to return to the abuser.

5) If a woman is considering leaving:

- Ask her if she has a plan for leaving, and how she has prepared/might prepare for this.
- Talk about making a checklist of important things to take, such as immigration papers or passports, birth certificates, bankbooks, the deed to the house, etc.
- Do not minimize her concerns for her pets, farm animals or property. Help her to determine what is most important to her and what she might do to protect them. Many women are not comfortable going to a shelter if they have to leave their animals behind.
- Inform her that it is extremely important that she see a lawyer knowledgeable about VAW so that she knows her rights. Many lawyers provide a free 1/2 hr. consultation and there is also a legal aid form available through shelters for abused women to see a lawyer.
- If a woman has children, tell her that it is very important that she take her children with her. It is also critical that she gets an interim custody order right away otherwise her partner could get a court order to take the children. Talk to her about how to do this.
- Discuss with her the increased risk associated with separation. Ask her how she thinks her partner might respond. Some abusers react by promising to change, others increase their threats and intimidation tactics.
- Understand that for most women, leaving is a process. Remind her to not tell her partner, or anyone close to him, about her plans.

Remember you may be meeting her at the beginning, middle or end of this process. The task is not to focus on her leaving but on reassuring her "she is not alone" and "it's not her fault." It's important for her to understand that she will be supported. Find out how she would like to be supported.

6) **The woman is in charge of her own safety planning (except when her capacity or strength are diminished):**
   - Clarify that your role may be limited to ensuring that she has information about the resources in the community and to help her explore which ones she might need now or in the future.
   - Communicate that she is not expected to make any decisions or plans today but that it is important that she think about staying safe.
   - Ask her what steps she would consider taking to protect herself (and her children).
   - Affirm that leaving is often a long-term process and depends upon her financial situation, the ages of her children, etc., and that it is important to plan for safety throughout this process.

7) **Recognize a woman's strength and capacity for taking control of her life:**
   - Recognize an abused woman's creativity and survival skills.
   - Affirm her strength and courage in the actions she has taken to date.
   - Acknowledge that she took a big step in sharing her story with you.
   - Indicate that she is the only person who can figure out what is best for her and her children, and that it takes time to do so.
   - Remind her that she is the expert in her situation and she has every right to ask for help with issues where she doesn't feel knowledgeable.
   - Encourage her to seek help, as it is hard for any woman to deal with abuse alone.

KNOWING HOW TO COMPLETE A SAFETY PLAN WITH A WOMAN IS EXTREMELY IMPORTANT. THERE ARE A NUMBER OF SAFETY PLANS AVAILABLE ON THE WEB. WE HAVE INCLUDED ONE THAT WE FIND PARTICULARLY HELPFUL IN APPENDIX 4-2 – WE STRONGLY SUGGEST THAT YOU FAMILIARIZE YOURSELF WITH THE ELEMENTS OF A SAFETY PLAN SO THAT YOU CAN ADDRESS HER SAFETY.

ASKING ABOUT MENTAL HEALTH AND RESPONDING TO MENTAL HEALTH CRISES

Many organizations that work with women believe they do not have the in-house expertise or staff time to adequately assess mental health problems. However, adding questions to current intake forms or procedures can help staff identify when there is a problem that requires more in-depth consideration. More knowledge will help staff feel more comfortable with these discussions.

It may initially feel awkward to ask women about their mental health and wellbeing. It may help to remember that many women say that DV, and in particular emotional abuse, has had a greater impact on their mental health than on their physical being.[3] Knowing more about the state of her mental health will help frontline workers plan appropriate interventions. For example, how should the symptoms of post traumatic stress disorder, such as dissociation or anxiety, be managed? What are the best ways of responding to a client's anger, depression, distress, or panic?

Frontline workers from other sectors may worry they lack the training to respond to women who are in emotional distress. But with some basic information and specific strategies and tools all frontline workers can offer effective assistance to distressed women.

You can:

- Create a safe environment for her to disclose her mental health problems.
- Explore the feelings and beliefs she has about herself as a result of DV.
- Help her understand the links between her current mental health and the violence she has experienced.
- Ask her how she feels about her diagnosis if she has received one. Remember some women are gratified to receive a diagnosis as it legitimizes their feelings and allows them access to more services including Ontario Disability Support Program.
- Reassure her that she is not "*sick*", "*nuts*", or "*crazy*". Recognize the likelihood that she has been described this way by partners and significant others.

Understanding trauma

One of the positive changes developing in mental health and substance use services is the move towards being "trauma informed." A trauma informed perspective requires an understanding of the specific ways that traumatic experiences shape and alter a person's mind, body and spirit. Understandably, traumatic experiences shape many domains of survivor's lives. The changes or alterations in survivors' cognitions and emotional regulation are often complicated and varied. These alterations or changes, when not understood through a trauma lens, are often seen as pathological, rather than viewed as understandable adaptations and ways of coping. Additionally, many abuse survivors respond to outreach and services with an expectation that they will not be understood or will be blamed or treated harshly if they are using drugs or alcohol. A trauma informed framework explains the dynamic interplay between the traumatic stressors and the complex and often diverse adaptations that people develop to survive.

But first it is important to understand how the brain's defensive systems respond to adverse and traumatic events.

How traumatic stress affects the brain and body

Women who are abuse survivors often have lived in environments where they were faced with the threat of constant danger. This danger could be in the form of emotional or physical abuse, neglect, abandonment or sexual violation. Living with constant fear results in a state of constant alertness. The amygdala which is located in the limbic system and is the defensive center in the brain, (the amygdala's function is similar to a smoke detector). The amygdala is where the fight, flight and submission responses take place. As well, sensory threat cues (sights, sounds, body sensation, and smells) are encoded here. The amygdala retains a database of threat cues to allow people to respond to danger quickly, and without thought.

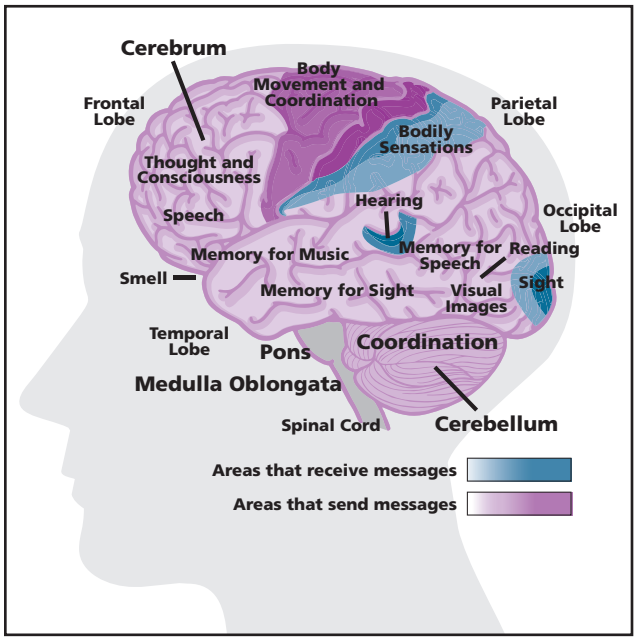


Image from: **www.hearthealthywomen.org**

When the amygdala detects threat, a cascade of neurochemicals from the adrenal glands initiates the adrenaline stress response. These neurochemicals are released in the brain to prepare the body for action, heart rate and respiration increase, oxygen flow to muscle tissue increases. As this is happening, other non-essential organ systems are turned off, including the part of the brain called the frontal cortex.

Understanding fight, flight and freeze responses

The chemicals released in times of stress lead to varied responses that fall into three primary categories: **fight, flight** and **freeze**. The fight response is often referred to as hyperarousal. The nervous system is revved up and preparing for action in response to danger. The flight response includes running, withdrawing or avoiding the threat. The freeze response is a shutting down. This response is what happens when fight or flight are not options or have not worked in times of danger in the past. This shutting down can also be a dissociative response.

Understanding dissociation

Some abuse survivors have learned to disconnect from overwhelming experiences when things become too intense for them to handle. Feelings, physical sensations, and thoughts associated with traumatic events may be fragmented and walled off from other memories. When these unwanted memories or sensations come up, people may attempt to disconnect from these sensations. This can look like someone is "spaced out" or "in a daze" or just does not feel connected to you in the moment.

Understanding triggers

Our body is designed to keep us out of danger. It remembers past signs of danger so that it can respond efficiently the next time something dangerous happens. If we're in constant danger, this efficient system is protective. However, sometimes something will remind us of a past danger even when we're not in actual danger. Reminders of past dangerous experiences are called **triggers**. Triggers activate the alarm system. When someone is triggered they may feel and act as though they are back in the time of danger, even though they are not. Women who live in conditions of constant danger or threat eventually experience a breakdown in the amygdala's ability to discriminate threat cues. As a result, abuse survivors begin to have persistent recurring overly defensive reactions to harmless stimuli. Simply said, when danger is ever present, the alarm (amygdala) goes off too frequently and the brain becomes conditioned to treat all potential threats as actual threats. When this happens, the brain is hyperaroused and reactive to any number of triggers. As a result trauma survivors feel chronically on high alert and are easily triggered to take flight or fight. Consequently, when triggered, the present feels like the past; survivors are not remembering their traumatic experiences they are re- experiencing them.

The relationship between trauma and substance use

It is essential that front line workers understand the neurobiological responses of traumatized women in order to know how to more effectively respond. Women who are traumatized have high levels of arousal that result in stress hormones being secreted through their nervous system.

Under conditions of chronic stress and/or threat, the neurotransmitters and neurohormones that facilitate the fight, flight, freeze responses become dysregulated or out of balance. The body is trying to manage being in constant danger. People experience these states as feeling overwhelmed, jumpy, and have a difficult time trying to find a place of calmness in their bodies.

In fact, research has shown that alcohol is one of the most effective ways to dampen high arousal. So it is not surprising that trauma survivors often develop problems with alcohol and other substances. Trauma survivors may also experience difficulties with learning and concentration (see **www.learningandviolence.net** for more on the ways violence and trauma affect learning). It is not hard to imagine the struggles with day to day functioning experienced by those with a hypersensitive brain, a number of potential triggers, and states of high arousal. Women who have endured ongoing arousal complain of persistent anxiety and panic attacks; an aspect of affect or emotional dysregulation. This relationship is further explored in the section on *Asking and Responding to Women's Substance Use*.

Helping women recognize and manage triggers

Front line workers can be proactive by recognizing and working to minimize potential triggers for the women they work with. Ideally, workers should ask women about the interventions they have found to be supportive and effective in the past.

Some of the common triggers that people react to include:

- Reminders of past events
- Lack of power/control
- Conflict in relationships
- Separation or loss
- Transitions and routine/schedule disruption
- Feelings of vulnerability or rejection
- Feeling threatened or attacked
- Loneliness
- Sensory overload (the feeling of being overwhelmed by sensations

Women who have experienced trauma may be triggered when they experience a lack of respect and safety and an absence of control and choice in a relationship or situation. These experiences often mimic and recall past traumatic experiences. People who are triggered will respond with a fight, flight, or freeze response. A fight response may appear as extreme anger or aggression that is seemingly disproportionate to the situation. A flight response may appear as physical or emotional withdrawal or by a client's not returning to your agency. When unable to take flight or fight, abuse survivors must find other ways to handle these overwhelming experiences. Some of the coping responses developed in response to trauma include dissociating, going numb, or disconnecting. Women who use persistent dissociation often have difficulty coping with even so-called "everyday stressors" because dissociation makes it difficult to stay present and learn alternative and more effective ways of responding or coping.

Indicators of Dissociation:

- Being in a daze
- Staring blankly into space
- Numbness
- Feeling dead
- Experience events, sensations and emotions at a distance
- Feeling detached from one's body
- Restricted emotional range
- Being on automatic pilot
- Feeling like a spectator. . .floating above the scene

Strategies to help clients de-escalate, manage triggers, dissociation and dysregulated emotional responses

De-escalation strategies describe ways to help people calm down before they reach the point of crisis. Key strategies include active listening, emotional validation, grounding, breathing relaxation. There are two major types of distressed behaviour and they require different responses: *Instrumental* and *Expressive*.

Instrumental behaviour is characterized by substantive demands and clearly recognizable objectives that, if attained, will benefit the person. These behaviours are best responded to through the strategy of problem solving. *Expressive behaviour* is motivated by the client's desire to communicate frustration, outrage, anger, despair, or other feelings. It can be difficult to reach a client who is highly aroused and having difficulty articulating his/her needs in an understandable way. She needs to vent and the best response is *active listening*. By using active listening skills, you can begin to build trust with her. When clients deal with substance abuse or mental health services they often have incredible fears, fears that they won't be treated fairly, or provided with the kind of help that they require, fears about authority and what is going to happen to them. When traumatized clients feel overwhelmed or powerless they often have heightened emotions and experience high levels of arousal (in the form of anxiety) — the

physiological response to threat and danger. Anxiety can lessen their ability to think clearly. During highly stressful situations, some women who have experienced abuse may disconnect from others when in crisis. If their need for support is not answered they often feel fear, anger, disappointment and utterly abandoned.

Using active listening skills with distressed clients

When listened to by others, distressed clients tend to listen to themselves more carefully and are able to evaluate and clarify their own thoughts and feelings. To help restore a woman's equilibrium and increase her ability to think clearly, you must avoid responding with behaviour that she may perceive as threatening. If she sees you as threatening, meaningful communication cannot take place.

Emotional labeling

With a highly aroused client needing to vent it is important to help her label the feelings expressed or implied by her words and actions. For example, you might say to a distressed woman:

"You sound as though you feel out of control and afraid about what this process involves."

When used effectively, emotional labeling is a powerful skill because it helps identify the underlying issues and feelings that are driving her distress.

Validation

Validation strategies are used to help clients understand that their responses make sense, their feelings or actions are valid given the particular circumstances. Emotional validation counters the experience many clients have of having their reactions minimized or punished. When clients feel understood they are often able to regulate their arousal and upset and will not feel the need to amplify what they are feeling in order to try to have some control. Being non-defensive in response to a client's anger or disappointment dramatically increases the likelihood of a positive outcome of the discussion. Remember that by listening we hope to be a 'safe container' for the women's anger; her anger is not personal. This may mean acknowledging a mistake, or an inadvertent use of a trigger word or phrase. For example, you might say to a distressed client:

"I am sorry I said that in that way. I can understand why that frightened you. Let me clarify what I meant."

Managing clients' anger

When working with women who are angry or violent, it is useful to talk about how you experience their anger rather than focusing only on their behaviour. Survivors do not always understand the impact of their action on others (in their childhood the impact of others' actions on them was often denied). When you describe your feelings about their anger you may be putting words to their childhood experiences. When you speak about the relationship from your experience you give the client the space to hear you without blame/shame. The client's behaviour may alienate others and make it difficult to help them.

Offer encouragement

It is important to be encouraging, to demonstrate that you are listening attentively and are focused on your client's words. This can be conveyed with body language or brief verbal replies that convey your interest and concern.

Pose open-ended questions

Avoid "why" questions which can result in some women feeling challenged. Instead focus on what the client thinks and feels. Effective open-ended questions include:

"Can you tell me more about that?"

or

"I really want to understand your experience. Can you tell me what happened?"
"What do you think would help you?"

Grounding techniques

Grounding techniques are meant to be remedies for a temporary condition of imbalance. This technique can help keep a person in the present, to feel safe in their surroundings and get back control when feeling triggered. Grounding is the most useful approach for dealing with dissociation, flashbacks or panic attacks.

The goal of any grounding technique is to help:

- Reconnect the woman to the present
- Orient her to the here and now
- Connect her to her body and personal control
- Connect her to you and the safety of the current space

These skills usually occur within two specific areas:

- Sensory awareness
- Cognitive awareness

When to use grounding

When a woman dissociates (which is what happens when a flashback takes over and the past becomes the present), a service provider can help reorient her and guide her back to the present by using their voice.

When a woman is experiencing a flashback

- Speak gently and firmly
- Give reassurance and information
- Validate her fear and tell her that she is having a flashback
- Help ground her to the present

Ways to ground

Frontline workers can also help women learn how to ground themselves when they are feeling panicky or triggered. Explain that grounding often takes the form of focusing on the present by tuning into it via all of one's senses. You could say:

"One technique involves focusing on a sound you hear right now, a physical sensation (what is the texture of the chair you are sitting on, for example?) and/or something you see. Describe each in as much detail as possible."

Sensory awareness grounding skills to share with clients

- Spritz your face (with eyes closed), neck, arms and hands with a fine water mister
- Put your feet firmly on the ground
- Listen to soothing music or familiar music that you can sing along to. Dance to it. How does it make your body feel?
- Rub your palms, clap your hands. Listen to the sound. Feel the sensation
- Hold something that you find comforting, it may be a stuffed animal, a blanket or a favourite sweater. Notice how it feels in your hands. Is it hard or soft?
- Carry something meaningful and tangible in your pocket that reminds you of the present. Touch it to remind yourself that you are an adult
- Try to notice where you are, your surroundings including the people present
- If you have a pet touch their fur and speak their name out loud
- Exercise. Ride a bike, stationary or otherwise. Lift weights. Do jumping jacks

Cognitive grounding skills to share with clients

Suggest she reorient herself in place and time by asking herself some or all of these questions:

- Where am I?
- What is today?
- What is the date?
- How old am I?

- What season is it?
- Who is the Prime Minister?
- What is happening right now?

Breathing control exercises

Increased respiration is one of the body's fight/flight responses. Abuse survivors often over-breathe as the breathing rate naturally increases in the presence of a perceived threat, causing hyperventilation and contributing to panic attacks.

Diaphragmatic breathing

Abuse survivors often hold their breath or breathe very shallowly. Constricted breathing can be an aspect of the body's freeze response. Breathing in this way deprives her of oxygen which can make anxiety more intense. Having her focus on deepening and slowing her breathing can help bring her back to the present moment.

The goal is not to change the breath but to explore the felt sense of it.

Place your hand on your diaphragm. As you breathe in (count 1-5 sec.) your hand should move.

When you breathe out (1-5) you hand should move again.

Square breathing

Breathe in through the nose, filling the lower lungs by extending the belly for a count of 3 or 4.

Hold the breath for the same count.

Then exhale completely for the same count, emptying the lungs by pushing with the belly.

Finally, rest while holding your lungs empty for the same count.

Repeat for 2 -3 minutes.

A BRIEF CONSIDERATION OF OTHER COMMON MENTAL HEALTH PROBLEMS

Depression

Clinical depression, also known as major depressive disorder or major depression, is the most common mental health problem in the general population affecting one in seven people at some point in their life. Major depression is characterized by a period of at least two weeks in which a person loses pleasure in nearly all activities and/or exhibits a depressed mood. Symptoms of major depression include feelings of sadness and hopelessness, diminished interest and pleasure, changes in weight and in sleep patterns, chronic fatigue, feelings of worthlessness or guilt and difficulty concentrating or thinking. These symptoms cause clinically significant distress or impairment in physical, social, occupational and other key areas of functioning.[4] In the Canadian population, the lifetime prevalence of experiencing a major depressive episode is 12.2%. Major depression is more common in women than in men, but the difference becomes smaller with advancing age;[5] women are approximately twice as likely as men to experience a depressive episode at some point during their life.[6] Biological, psychological and sociocultural factors are all involved in the development of depression. Some common factors related to the development of depression include previous depression, feelings of being out of control or overwhelmed, chronic health problems, traumatic events in childhood or young adulthood and lack of emotional support. Women who are lone parents are more likely to experience depression than women generally.[7] Providing support and letting the person know that you are willing to help can be helpful. Try to ensure the individual is connected to a mental health professional or family doctor.[8]

To learn more about this topic see:
http://www.mooddisorderscanada.ca/documents/Publications/%20DepressEngMasterFeb2011.pdf
or
http://ubc-mooddisorders.vch.ca/docs/Recognizing_Depression.pdf

Self-harming behaviour

Self-harm is a behaviour that involves unambiguous injury to the body in an effort to diminish or provide temporary relief from psychological distress. Self-harm is distinguished from suicide-related behavior by the lack of suicidal intent.[9] The causes are multifactorial, and biological, psychological, and social explanatory theories have all been offered.[10] Some see self-harming behaviours as a woman's response to relational and cultural violations and silencing of the self, while others see it as a response to the helplessness and powerlessness associated with experiences of trauma.[11] It has been noted that self-harming behaviours serve many different functions for the individual; they can be a way of coping with stress, regulating unpleasant emotions, calming and comforting, relieving a sense of guilt, restoring a sense of reality, and providing a means of communicating distress to others.[12] In response to the tremendous stigma and guilt associated with self-harm, some organizations have begun to use the language, self-soothing, to refer to these behaviours.[13] It can be difficult to distinguish between self-harm and suicide-related behaviour as both are self directed and dangerous. However, the majority of individuals who engage in self-harm do not wish to die.

Suicide-related behaviour

While not all suicides are preventable, familiarity with the risk factors and warning signs may enable greater recognition of those at heightened risk of suicide. While familiarity with these signs is encouraged completing a formal suicide assessment using a standardized tool requires specialized training. There is a new standard requirement for Canadian mental health settings that they address the immediate and ongoing safety needs of persons identified as being at risk, and appropriately document risks and interventions in that person's health record (Accreditation Canada, 2011).

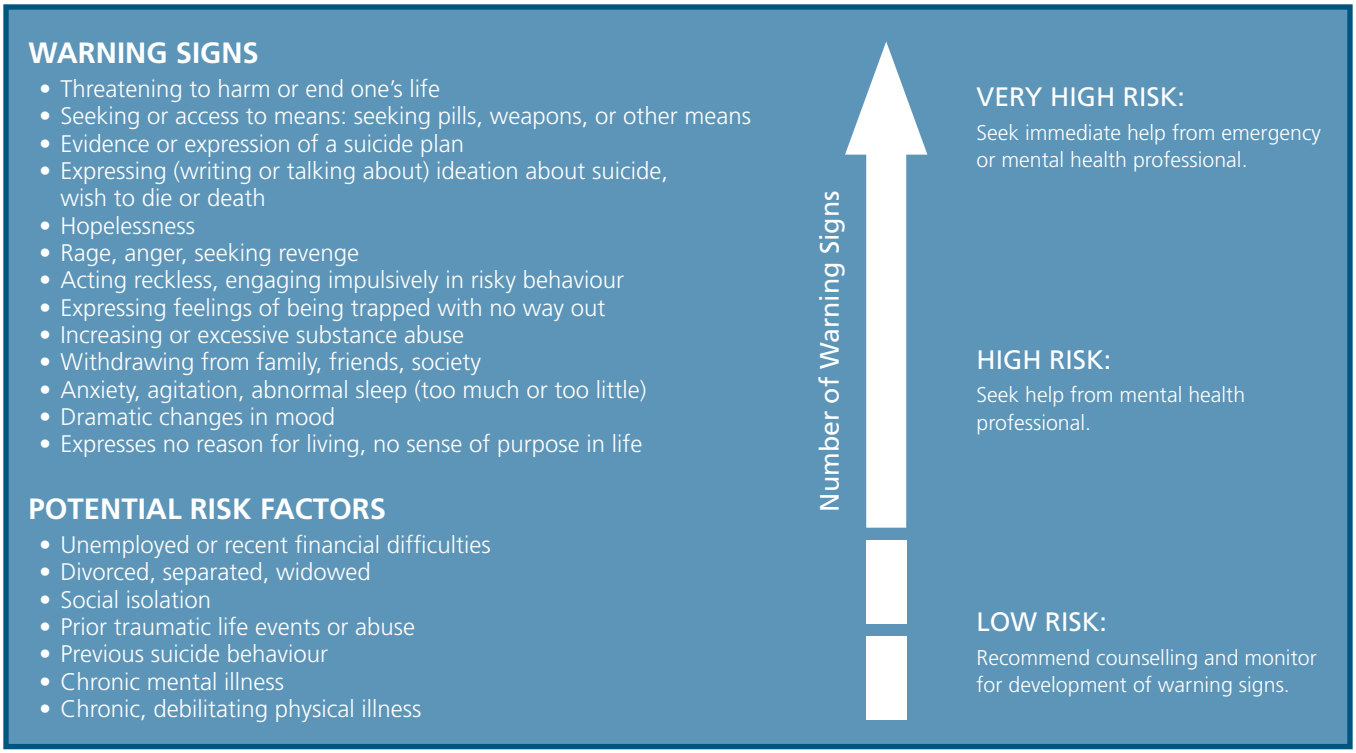
Perlman and colleagues note in a recent document, Suicide Risk Assessment Guide: A Resource for Health Care Organizations, that it is important to distinguish between factors known to be correlated with suicide (i.e., potentiating risk factors) and the extent to which they are known to actually increase risk of imminent suicide (i.e., warning signs). The authors explain: "Potentiating risk factors are associated with a person contemplating suicide at one point in time over the long term. Warning signs are factors that may set into motion the process of suicide in the short term (i.e., minutes and days)... Therefore, though warning signs indicate the person's level of risk, the potentiating risk factors present areas of focus for interventions (pp 5-6)."[14]

A suicide risk assessment also considers and enhances an individual's protective factors such as:

- Strong connections to family and community support;
- Skills in problem solving, coping and conflict resolution;
- Sense of belonging, sense of identity, and good self-esteem;
- Cultural, spiritual, and religious connections and beliefs;
- Identification of future goals;
- Constructive use of leisure time (enjoyable activities);
- Support through ongoing medical and mental health care relationships;
- Effective clinical care for mental, physical and substance use disorders;
- Easy access to a variety of clinical interventions and support for seeking help;
- Restricted access to highly lethal means of suicide.[15]

A discussion of a woman's risk factors, warning signs, and protective factors can be an integral part of the therapeutic process.

Risk Factors and Warning Signs on Risk of Suicide[16]



For more on this topic see:
http://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf

Conclusion

Women who have experienced DV or other forms of abuse can respond in widely varying ways to the extreme levels of chronic stress and loss they have faced. The assistance provided by front line workers plays a pivotal role in helping women feel confident about making positive changes in their lives. Without effective strategies and approaches, it is challenging to work with a woman's intense expressions of traumatic reactions. Understanding the impact of trauma is an important tool. Helping women manage their hyper-arousal, avoidance, and dissociation will be enormously helpful. But most importantly, women who have experienced abuse need to feel validated, understood and not judged.

ASKING AND RESPONDING TO WOMEN'S SUBSTANCE USE

Asking about substance use in a supportive and respectful way and creating a safe space for disclosure, creates an opportunity for a woman to consider any problems she may have in managing her substance use, engage in a discussion about how substance use may impact her (or her children's) safety, and identify the pros and cons of her substance use. It also helps workers understand how best to help her whether this is by offering her information, support, resources or a referral. Creating the safe spaces for women to discuss their substance use requires the same skills as supporting disclosures of DV or mental health problems; specifically, maintaining a

nonjudgmental attitude, actively listening, recognizing the courage required to disclose, normalizing the experience, and acknowledging the woman's strengths and autonomy. These same skills should be applied even when standardized questions or screening tools are used.

Substance use as a coping strategy

Substances such as alcohol, tobacco, or prescription medications are part of daily life. Often they help individuals manage uncomfortable feelings such as stress, distress, disappointment or anger by activating changes in the brain. Problematic substance use can also be understood as a coping strategy, an attempt to regain balance between the mind, the body, and the spirit. For example, alcohol has been shown to effectively relieve symptoms of traumatic stress (e.g. anxiety, depression, memory recall, dissociation, flashbacks, abusive relationships, emotional and physical pain, somatic complaints, etc.).[17] Although substance use may be effective in helping women manage some symptoms and issues, problematic substance use can leave her vulnerable to harmful experiences and other health issues. Helping her recognize that her substance use may increase her risk of abuse or other harms can lead to a discussion of ways to minimize this risk and steps she can take to enhance her safety.

How substances affect the brain

Human behaviours and emotions are modulated by neurotransmitters that act as keys between neurons. The amount of any given neurotransmitter in the brain's circuits is precisely controlled by numerous feedback mechanisms, somewhat the same way that a thermostat keeps a room around a certain temperature.

Drugs are substances that disturb this delicate balance, because they have "passkeys" that let them open certain "locks" located between the neurons. The brain automatically adjusts to these substances from outside the body by producing fewer of its own natural "keys." It thereby achieves a new state of equilibrium that is maintained until the body starts to miss the external substance. At that point, the person experiences a craving that will persist until the neurons that went on vacation get back to work.

Among the brain circuits most affected by drugs is the one associated with pleasure. This reward circuit that is overstimulated by drugs uses a particular neurotransmitter called dopamine. So researchers were not surprised to discover that most drugs that cause dependencies increase the amount of dopamine in the reward circuit.

They do so in different ways. Drugs act by imitating, stimulating, or blocking the effects of certain neurotransmitters.

The brain's synapses can adapt to the chronic presence of a drug in various ways. For example, in some cases, to try to compensate for the sudden increase that a drug triggers in the concentration of a neurotransmitter, the synapses reduce the number of receptors for this neurotransmitter. In other cases, they simply make these receptors less sensitive to this neurotransmitter, so that it binds to them less efficiently. Both of these mechanisms are very common in chronic consumers of alcohol, opiates, nicotine, and benzodiazepines.

The above material was downloaded from the website: http://thebrain.mcgill.ca/flash/index_d.html

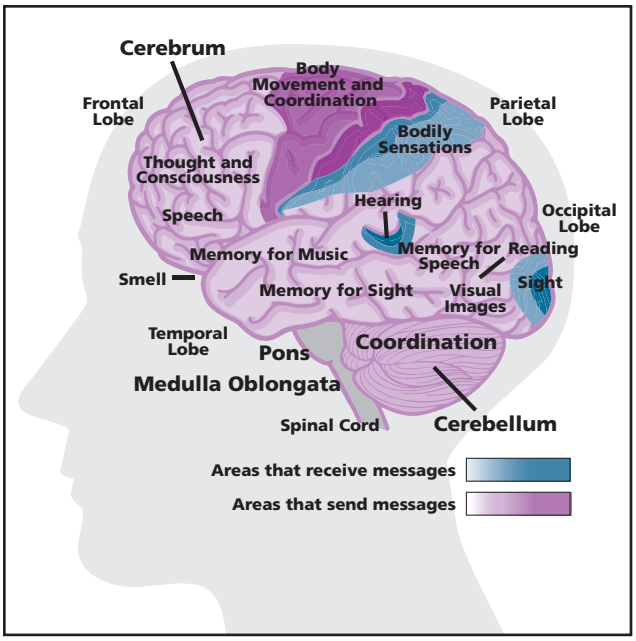


Image from: **www.hearthealthywomen.org**

Signs and symptoms of substance use

- smell of alcohol
- signs of IV drug use (tracks)
- unusual or extreme behavior
- nodding off
- overly alert
- slurred or rapid speech
- staggering
- tremors
- glassy-eyed/pupils dilated or constricted
- unable to sit still
- disoriented or confused for no apparent reason
- argumentative, defensive, or angry when asked about substance use.

Remember, however, some of these same behaviours may be the result of traumatic stress or the signs/symptoms of a cognitive or physical disability. For example, in the case of an acquired brain injury, which can be caused by either substance use or violence/head trauma, common symptoms include confusion, disorientation and agitation. Similar symptoms may also be evident in some mental health problems or may be side effects of prescription medications.

Health Canada recommends that all mental health services screen for substance use and all substance abuse treatment centres screen for co-occurring mental health problems. (CAMH.net Screening and Assessment for Concurrent Disorders). At this time there have been no such recommendations for VAW services or shelters. Nevertheless there are many who advocate for routine screening in the belief that this knowledge is critical in helping women get the help they need.

The first step when introducing discussions about substance use into your organization is to consider the level of information you require in order to effectively deliver service. It may be sufficient to know whether she has concerns about her substance use, or if she thinks her substance use may be affecting her safety or the safety of others. In such instances open ended questions, like "Would you like to discuss your substance use?" Or, "Do you have any concerns about your substance use and how they may be affecting your life? Or, "Do you think your substance use may be impacting your safety or the safety of others?" may be sufficient. Remaining open and nonjudgmental will allow her to respond and you to begin working collaboratively with her.

Some organizations routinely screen for substance use, sometimes as a way of excluding individuals from service. "Overall, women's safety should remain the paramount concern. If there is need to consider excluding a woman from the service because of her behaviour when using substances, ensure she has other options for support/accommodation. It is important that she is not exposed to violence and other stresses due to her drug or alcohol use."[18] Other organizations screen when there are indicators

or suspicions about substance use while still others choose to create an environment where it is safe for women to disclose their substance use in their own way. Whichever approach is utilized building rapport, trust and maintaining a nonjudgmental attitude are essential.

Screening is not the same as assessment or making a diagnosis, both of which involve more in-depth consideration of the individual and her circumstances. Asking screening questions or completing an assessment should be undertaken in order to provide women with the best, most appropriate help, individualized to her particular circumstances and needs. Learning more about a woman's substance use is helpful so you can work with her on assessing current and future risks to her safety, health and wellbeing, however, the level of detail you may require is likely to differ depending upon the service you deliver.

Among the wide variety of screening tools available, the most common are those used to determine alcohol usage. The Centre for Addiction and Mental Health (CAMH) suggests a screening tool called CAGE to screen for lifetime alcohol use.[19] However, Bradley and colleagues (1998) note that "brief alcohol screening questionnaires may be less sensitive for alcohol abuse or dependence among women than among men, particularly screening questionnaires…" (p. 170) [20] and that lower cut off points for women should be considered. They recommend that in women one positive response is suggestive of a current or past problem with alcohol.

CAGE

1. Have you ever felt you should **C**UT DOWN on your drinking?
2. Have people **A**NNOYED you by criticizing your drinking?
3. Have you ever felt bad or **G**UILTY about your drinking?
4. Have you ever had a drink first thing in the morning (an **E**YE OPENER) to steady your nerves or get rid of a hangover?

Bradley et al. (1998) suggest another, more effective screening instrument for women, TWEAK, when scored with 2 points or more indicative of a problem with alcohol.

TWEAK

T **T**olerance: How many drinks can you hold ("hold" version ≥ 6 drinks indicates tolerance), or how many drinks does it take before you begin to feel the first effects of the alcohol? ("high" version ≥ 3 indicates tolerance)

W **W**orried: Have close friends or relatives worried or complained about your drinking in the past year?

E **E**ye openers: Do you sometimes take a drink in the morning when you first get up?

A **A**mnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

K **K**ut down: Do you sometimes feel the need to cut down on your drinking?

Health Canada's report on best practices in screening for co-occurring mental health and substance use (2002) did not include asking about experiences of DV[21] but does highlight some of the common consequences of substance use in people with *severe* mental health problems. Health Canada advises asking about substance use in the presence of the following:

- housing instability;
- difficulty budgeting funds;
- symptom relapses apparently unrelated to life stressors;
- treatment non-compliance;
- prostitution;
- social isolation;
- violent behaviour or threats of violence;
- pervasive, repeated social difficulties;
- sudden unexplained mood shifts;
- employment difficulties;
- suicidal ideation or attempts;
- hygiene and health problems;
- cognitive impairments;
- legal problems.

Educating providers on the many psychosocial issues associated with substance use problems can lead to greater comfort in raising these issues with clients.

Safety

Substance use impacts safety in different ways. In addition to the more obvious risks associated with the substances themselves, she may also increase her risk of re-victimization by being unaware of imminent danger, by putting herself in dangerous situations, and by entering dangerous environments. Asking some of the following questions may help determine her awareness of these safety issues.

- Have you ever gotten into conflict with the law while under the influence?
- Have you ever engaged in self-injurious behaviours while under the influence?
- Do you have a safety plan including a harm reduction and/or relapse prevention plan? *(Be prepared to explain what harm reduction is. Many people use harm reduction strategies every day and don't know that they are doing so)*
  - o Do you practice harm reduction? What harm reduction strategies do you use?
  - o Are you currently working with a harm reduction, outreach, or addiction worker?

Frontline workers may struggle with being a witness to her increased risk of re-victimization as a result of her substance use. Reconciling concerns for her safety while also supporting her autonomy, the right to make her own choices and decisions, can be difficult. Peer support and supervision can help frontline workers manage these concerns.

Some organizations have policies where abstinence is a precondition of residence or service. VAW shelters, transition houses, as well as some counselling agencies have argued that women who are using substances lack the self-control and perception to work on their other problems. Shelters in particular have also argued that they lack the means to keep safe both the substance using woman and other residents including children, and further that substance using women create disruption and turmoil in the house due to their inability to function in a collective residential environment. Nevertheless some shelters and other organizations have adopted a 'harm reduction' approach to service delivery that is designed to meet the needs of vulnerable substance using women as well as other clients.

Harm reduction strategies

It's an ongoing challenge. You know, it sort of depends on who's working, how comfortable they are… So we're really working hard with education and training about what are the realities of someone who has substance use issues and abuse issues and what are the signs we should be looking for, and what are the things we need to be wary of in terms of health risk

and things like that. So it's an ongoing process, and some staff are more receptive than others.
(Chatham, ON Round Table Participant)

The most important is the way that we are seeing our clients as a whole, not as pieces. So now it's a person, it's a human being with so many different issues that we cannot take one away and say oh, she's mental health, we can't take her. She's a person, a human being, and we try to help and support her in all kinds of different ways. These kinds of meetings help us figure out exactly where to go with a woman in need. Of course that is difficult because if we don't have any other shelter to call — then how do we do it? But I feel that there is good support from the whole management team, and the board of directors, and the staff saying okay, let's go for training. We need more training, so we find more training…So it's not easy, it's very difficult, but we need to do it.
(Chatham, ON Round Table Participant)

While many believe that treating substance use problems requires abstaining from all substance use, increasingly there is a move towards employing a harm reduction approach. Harm reduction places a greater focus on helping individuals choose the level and type of change they would like to make in their use of substances and supports the introduction of other changes that reduce the harms associated with substance use, for example inadequate housing, nutrition, and lack of personal safety. Harm reduction has been described as a set of "compassionate and pragmatic approaches for reducing harm associated with high risk behaviors and improving QOL (quality of life) (p.5)."[22]

By using harm reduction strategies women can protect themselves from some of the risks and harms associated with their alcohol or drug use and make better informed decisions about their personal safety. A harm reduction approach also reduces the stigma associated with substance use by accepting that substance use is part of society.

Harm reduction strategies may include:

- Helping her understand the connections between substance use, abuse, and trauma
- Encouraging healthy eating, adequate rest, and other healthy behaviours
- Reducing frequency, amount, or number of substances used
- Using substances with a buddy
- Only using alcohol or drugs with known people
- Using alcohol or drugs at their own home
- Not using substances with their partner
- Carrying condoms
- Having a harm reduction worker
- Attending peer support groups, etc.
- Not driving any type of vehicle while using substances
- Always having clean equipment with proper disposal
- Only using their own equipment

Shelters that have adopted a harm reduction approach have developed strategies to maximize their client's safety. Some of these include:

Making sure all staff and residents recognize that substance using women are among the community's most vulnerable and that substance using women are included in the shelter community. This is made clear during the intake process.

Developing a policy that allows women to use substances off site and still maintain their residency as long as they are able to safely navigate to their room and do not cause disruption in the house. For an example of one such policy, see Appendix 4-1.

Setting up a lock box at the main desk or locker in each resident's room to safely store harm reduction supplies and drug paraphernalia.

Ensuring all staff members are educated about trauma, substance use, withdrawal, and overdose.

Setting aside a quiet space or room for those residents who require monitoring due to concerns related to their incapacity.

Providing onsite harm reduction or substance use counselling either by co-location agreements with other organizations or by hiring trained staff.

Developing agreements with local detox or withdrawal management programs in order to support women on methadone in the shelter.

Developing creative strategies to minimize the disruption caused by residents who do not participate in house chores. For example, one shelter has developed a form of payment (in this case transit tokens) for residents who do household chores; if one resident doesn't complete her assigned chore, there's always someone else eager to do it for her.

As a worker you must follow your organization's substance use policy, even if you don't agree with it. If there are policies that you don't agree with or would like to change, work with your agency on ways to improve policy, operation, and service provision.

Understanding the process of change

Making change is rarely a discrete, single event. In fact, it is now more commonly understood as a process involving identifiable stages with both forward and backward movement. This process, the way an individual sets about changing some aspect of their behavior, has been described by Prochaska and Di Clemente as the Stages of Change Model (1984). The model has been applied to smoking cessation programs, to understanding how women who experience DV decide to leave the relationship, and to substance use recovery. By using the model, frontline workers can determine the best intervention at this moment for that particular client. Another benefit of the model is that it helps clarify why some interventions work well with one person but not another and why women sometimes return to earlier behaviours.

The Stages of Change Model shows that for most individuals changing behaviour occurs gradually beginning with a state of disinterest, lack of awareness or unwillingness to make a change (precontemplation), to thinking about a change (contemplation), to deciding and preparing to make a change (preparation). Taking the step into action (action) is followed by learning how to maintain (maintenance) the new behaviour. Within this model, returning to an earlier stage is almost inevitable and is considered part of the process of working toward lasting change. The appropriate intervention(s) for each stage appears on page 90.

Motivational Interviewing

Motivational Interviewing (MI) is a way of approaching discussions of change that has been shown to be particularly helpful in identifying and supporting an individual's own motivation for and commitment to change. MI has been defined by its developers as "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change (p. 129-140)."[23] A central concept of MI is the identification, examination, and resolution of ambivalence about changing behavior, where ambivalence is recognized as a natural part of the change process. MI is grounded in a respectful collaborative relationship where it is recognized that the agent of change is the individual woman or client. In supporting the individual's capacity to change MI embraces a strengths-based focus.[24] Although becoming proficient in MI requires specialized training, many of the techniques can be usefully applied to everyday practice. The acronym, OARS, has been developed to reference MI's key features:

O - open-ended questions

A - affirmations

R - reflective listening

S - summaries

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month	Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with triggers, relapse, or desire to return to prior behaviours
Relapse or return to prior state	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse or return to prior behaviour Reassess motivation and barriers Plan stronger coping strategies for subsequent attempt

From http://www.cellinteractive.com/ucla/physcian_ed/stages_change.html

Avoiding arguments and making assumptions about an individual and their motivation to change (or not change) is another useful tip that can be applied in any client interview or discussion. However, other MI strategies and techniques, such as "rolling with resistance," require practice and experience. To learn more about Motivational Interviewing visit: **www.motivationalinterview.org**.

Supporting women who want to make some change in their use of substances

Frontline workers can use the following suggestions to support clients who are at some level of change:

- Create a safety plan with her. This should include:
  - o Identification of triggers, high risk situations, thoughts and feelings
  - o Identification of "warning signs" (thoughts and feelings) of substance use
  - o Identification of boundaries to substance using (harm reduction)
  - o Development of alternative coping strategies to using substances
  - o A plan for high risk situations
  - o Getting her connected to a substance use, harm reduction, Hep C, or Outreach worker
  - o Providing her with harm reduction and/or relapse prevention education
- Encourage her to cut down on the frequency or amount used
- Suggest she delay using alcohol or drugs by distraction (calling someone, tv, walk, sing, etc.)
- Encourage her to set substance use boundaries around appointments (e.g. not to use substances 12 hours before appointment, progress to not using substances 12 hours after appointment)
- Have her plan her substance use to maximize safety and minimize harm
- Suggest she change the people, places, and things she associates with using substances
- Help her set a budget and encourage her to stick to it
- Encourage her to spend more time with non-substance using supportive friends, family, peers, or professionals

Strategies to suggest she use in dealing with cravings

- Identify that you are experiencing a craving (what are the thoughts and feelings associated with a craving?)
- Discover ways that soothe the craving (massage your shoulders, chew an ice cube, have a bath, etc.)
- Remember the craving will go away
- Encourage self-care
- Encourage creative discovery of healthy coping strategies
- Prepare for cravings (know what situations, people, places and things trigger cravings and prepare for them by having a safety plan)
- Practice mindfulness, relaxation, and grounding strategies
- Attend support groups and programs
- Introduce mindfulness, relaxation, and grounding techniques
  - o Provide free yoga and mindfulness classes
  - o In programming and individual sessions introduce clients to mental, physical, and soothing grounding and relaxation exercises that she can practice on her own
  - o Introduce diaphragmatic or 4 square breathing (for full directions see the section on trauma and grounding)

Other safety concerns

Substance use is also a factor in abuse and violence. Her partner may use her substance use as a way to control and manipulate her. She may use substances as a way to cope with the emotional and physical pain of the abuse. She may be influenced by her partner's use or have been forced to start using alcohol or drugs against her will. She may have been forced to buy/sell drugs, forced into the sex trade, or forced into other criminal activity. Knowing about how substances figure in her life is important for knowing how to help her plan for her safety.

SUBSTANCE USE AND DV

Do you feel your substance use jeopardizes your safety? If yes, how so?
Does your partner/ex-partner use substances?
Do you use substances together? If so, has any violence occurred between you while under the influence?
Does your partner attempt to control your substance use?
Does your partner ever force you to use substances against your will?
Has your partner ever forced you to buy or sell drugs?
Has your partner ever forced you to do sex work for drugs?
Have your previous efforts to stop using substances ever been sabotaged by your partner/ex-partner?
Has your substance use increased with your experiences of violence? Please explain.
Have you ever been assaulted/assault someone else when you were under the influence?

Symptoms of substance withdrawal

Alcohol: Alcohol withdrawal symptoms usually occur within 5 - 10 hours after the last drink, but can occur days later. Symptoms get worse in 48 - 72 hours, and may persist for weeks. A severe form of alcohol withdrawal called delirium tremens can cause: agitation, severe confusion, seeing or feeling things that aren't there (hallucinations), fever, and seizures.

Opiates: Symptoms usually start within 12 hours of last heroin usage and within 30 hours of last methadone exposure.

Stimulants: Amphetamine withdrawal often has no visible physical symptoms like the vomiting and shaking that accompanies the withdrawal from depressants such as heroin or alcohol. The craving and depression can last for months following cessation of long-term heavy use of stimulants (particularly daily). Withdrawal symptoms may also be associated with suicidal thoughts in some people.

Risk Factors for an Overdose

- Recent period of abstinence: tendency to use the same amount of a drug as before but tolerance may have dropped
- Relapsing: can have lowered tolerance and addition of emotional component (feeling like they might as well do as much as possible or feeling like a failure) cause overuse
- Detox program (as little as 3 days): lowered tolerance
- Incarceration (even a weekend): lowered tolerance
- Using alone: no one to notice if OD'ing
- Mixing drugs: causes unexpected reactions

Symptoms of an opiate overdose

- ***Somnolence . . .*** Can't waken (doesn't respond to painful stimuli)
- ***Respiratory depression . . .*** very slow and ultimately no breathing (apnea)
- ***Cyanosis . . .*** Turning blue, around lips and fingers first
- ***Pinpoint pupils***
- ***Cold or clammy skin***
- ***Bradycardia . . .*** slow heartbeat (<50)

All of which can progress to: *cyanosis* (breathing is too slow) leading to *apnea* (breathing stops) and *cardiac arrest* (the heart stops because it's not getting oxygen) and *circulatory collapse* (circulation of blood to the brain stops).

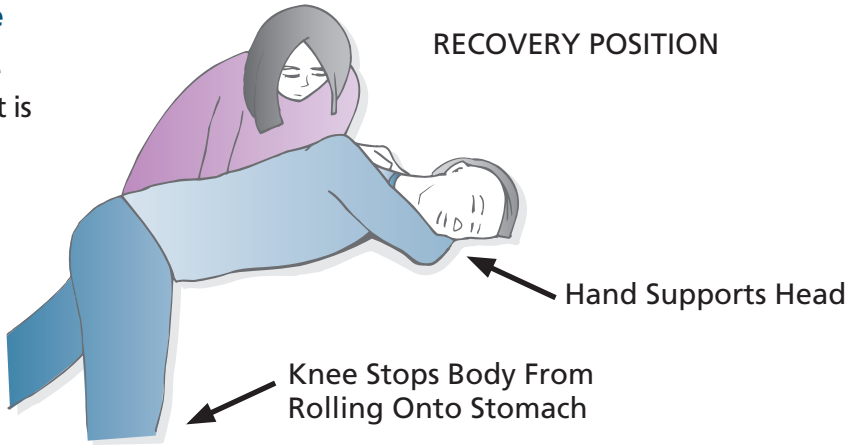
Symptoms of a stimulant overdose

- ***Collapse…*** heart or breathing may stop, or they may have a seizure
- ***Extreme agitation, shaking or chest pains—or aggression…*** may indicate an impending overdose
- ***Complaints of chest pain, shortness of breath, disorientation, and panic…*** may indicate an impending overdose

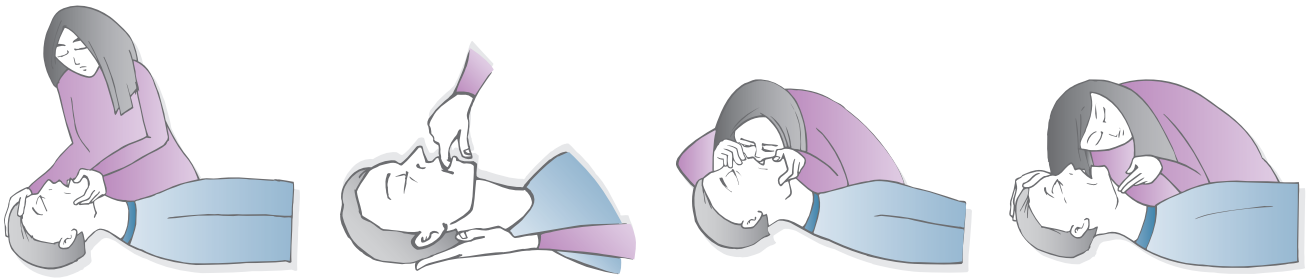
All of which can lead to a seizure, heart attack, or stroke resulting from dangerously elevated body temperature, pulse and blood pressure, and from dehydration and other causes.

Responding to an overdose

If the woman is unresponsive and cannot be awakened but is breathing, place her in the recovery position and call for help.



If she is not breathing Call 911. Roll her onto her back, clear airway and begin rescue breathing.



Conclusion

In conclusion you don't have to be an expert in substance use, but understanding the role of substance use and how it relates to DV issues and safety concerns is crucial in providing appropriate services. Knowing how to approach the subject, screen for substance use, and identify client's motivational levels will help assist workers in identifying the most appropriate intervention for their clients.

Knowledge of community resources and developing a collaborative working relationship with such organizations are beneficial to both the client and worker, as efforts to support mutual clients are shared. You will find more information about how to develop effective collaborations in Section 5 of this manual.

Nondisclosure: Why she may choose to not disclose DV, mental health or substance use

There are many reasons why a woman may choose to not disclose DV or mental health and substance use issues. It is extremely important to recognize and understand how difficult it may be for a woman to talk to someone about her situation because:

- She has never disclosed to anyone before, and she may be ashamed or afraid of being judged or not believed
- She told someone before about her experience of abuse, her mental health issues or substance use and she is being blamed for her situation
- It is against her cultural values to talk to a stranger about private matters
- She believes that she deserves to be abused
- She is financially dependent on her partner
- Her partner has threatened her if she tells anyone
- She is not ready to end the relationship or is still minimizing what is happening
- It will affect her immigration status
- Others will find out about her sexual orientation or "out" her sexual orientation. She may also be afraid that the health care provider will be homophobic
- She is concerned about getting her partner in trouble
- She does not know what she has experienced is abuse
- Her situation will not be understood
- Her children will be taken away from her
- There is a language barrier
- If she discloses her use of substances she may not qualify for services or be forced to stop, which may mean she loses her coping choices

Interventions for children at risk

The Child and Family Services Act sets out the legal obligation regarding the duty to report. The duty to report applies to everyone, a responsibility, which cannot be delegated. You have an obligation to report if a person has "reasonable grounds to suspect" that a child is in need of protection which includes harm or risk from physical, sexual or emotional abuse or neglect.

"Reasonable grounds to suspect" means there is enough information for an average person, exercising normal and honest judgment, to make a decision to report. It is less information than would be required to make the person absolutely certain.

Professionals have a higher duty to report than other members of the public and can be fined up to $1,000 if they fail to report their suspicions that a child may be in need of protection.

Who is considered a professional?

Professionals include:

- health care providers, including physicians, nurses, dentists
- teachers and principals
- social workers and family counselors
- religious leaders
- day care workers

- youth and recreation workers
- police officers
- workers in the violence against women field

What do I have to do?

The duty to report overrides any organizational policy pertaining to confidentiality. The duty to report is ongoing until action is taken – if there is no apparent response or you believe the child is being harmed or at risk of being harmed, you must report again as often as necessary.

NOTE: Although the Act is meant to place more responsibility on our community of workers to be aware of child abuse and neglect issues, one of the negative repercussions is that a woman could become even more reluctant to disclose about abuse, mental health or substance use issues for fear that her children will be taken away. If the woman is experiencing violence, fear of disclosure could put her and her children's safety even more at risk, and prevent her from seeking the help that she needs.

However, if a woman has taken or is taking steps to protect the children from exposure to woman abuse, reporting to child protection authorities may not be required.[25] This could include a woman who has:

- realistic plans to seek custody of her children
- come to a shelter with her children to live
- taken steps to find housing for herself and her children
- reported the abuse to the police so her abuser can be charged
- hired a family law lawyer

However, circumstances can change abruptly and subsequent events may require a report being completed.

What is the impact of a child protection investigation?

For women experiencing domestic violence who have children, the involvement of a child protection agency adds tremendous pressure to situations that are already difficult and uncertain. It becomes even more complex if there are issues of mental health and/or substance use. Although statistics indicate that children are rarely taken into care, the fear of having one's children taken away once an investigation begins is very real.

Other potential impacts of a child investigation could be:

- Women feeling that their parenting will be blamed. Often they may feel that they will be blamed for the abuse that is not their fault, even if they have tried to protect themselves and their children. Under the *Child and Family Services Act*, the fact that a mother cannot escape from an abusive relationship could be construed as her "failing to act" to protect her child from emotional or physical harm
- The parenting of women of low income, women with disabilities and immigrant women may be scrutinized more harshly because they might have fewer resources on which to rely for help, or because their parenting style does not fit a particular norm
- If it is felt that the risk to the child is immediate, a child protection agency may force a woman to make drastic changes in her life, like go to a shelter, when she does not have the emotional or financial resources to leave, without offering long-term protection and support
- A tactic used by the abuser, the threat of calling a child protection agency to ensure that the woman remains silent about the abuse
- An investigation could exacerbate an abusive situation at home. The partner could become more abusive, especially if there is suspicion that the woman or children reported the abusive behaviour

- Children often feel at fault for witnessing or experiencing abuse or disclosing this information to anyone. They may feel afraid of the consequences to the abuser, their mother or repercussions to themselves

However, the involvement of a child protection agency is not always a negative experience. Concerns raised by the agency can provide an important "reality check" to a woman about the effect that violence is having on her children. Child protection workers can also become part of the integrated service to protect and ensure safety from violence for the woman and her children. They can provide safety planning for women, link them to a shelter, financial resources, counselling, and orient them to legal protection. Although child protection agencies are mandated to perform specific duties and obligations based on the *Child and Family Services Act*, each region or community may interpret their obligations differently.

It is highly recommended that you contact your local child protection agency(ies) to obtain more information on making a referral and investigative procedures.

Other exceptions and limitations to confidentiality exist including:

1. When suicide risk is suspected. (Ontario's and British Columbia's information and privacy commissioners recently produced a Practice Tool to support decision-making in situations where individuals may be at risk of suicide. A quote from this document makes our ethical and legal responsibility unambiguously clear, "… life trumps privacy, and our laws reflect that reality." For a copy of the tool go to **http://www.oipc.bc.ca/pdfs/Policy/ipc-bc-disclosure-edu.pdf**
2. When there is an imminent danger to an identifiable third party
3. When a disclosure is ordered by the court or required by other legislative acts
4. In cases where involuntary hospitalization in a designated mental health facility is warranted. The Mental Health Act allows a doctor (by completing a Form 1) or a justice of the peace (by completing a Form 2) to hospitalize a person involuntarily for a period of three days for a psychiatric assessment.[26] In such cases, all four of the following criteria must be met and:
   a. The person is suffering from a mental disorder that seriously impairs their ability to react appropriately to his or her environment or to associate with others
   b. The person requires psychiatric treatment in or through a designated facility
   c. The person requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others
   d. The person is not suitable as a voluntary patient

References

[1] Chen, P-H., Rovi, S., Washington, J., Jacobs, A., Vega, M., Pan, K-O., & Johnson, M.S. (2007). Randomized comparison of 3 methods to screen for domestic violence in family practice. *Annals of Family Medicine, 5*(5), 430-435. doi: 10.1370/afm.716.

[2] Campbell, J.C., Webster, D.W., & Glass, N. (2008). The danger assessment: Validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence, 24*(4), 653-574. doi: 10.1177/0886260508317180.

[3] Walker, L.E. (1979). *Battered woman.* New York, NY: Harper and Row.

[4] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR).* Arlington, VA: American Psychiatric Association.

[5] Patten, S.B., Wang, J.L., Williams, J.V., Currie, S., Beck, C.A., Maxwell, C.J., & El-Guebaly, N. (2006). Descriptive epidemiology of major depression in Canada. *Canadian Journal of Psychiatry, 51*(2), 84-90.

[6] Stewart, D., Gucciardi, E., & Grace, S. (2003). Depression. In M. DesMeules, D. Stewart, A. Kazanjian, H. McLean, J. Payne, & B. Vissandjee (Eds.) *Women's health surveillance report: A multi-dimensional look at the health of Canadian women.* Ottawa, ON: Canadian Institute for Health Information. Retrieved from **http://www.phac-aspc.gc.ca/publicat/whsr-rssf/pdf/CPHI_WomensHealth_e.pdf**

[7] Stewart, D., Gucciardi, E., & Grace, S. (2003). Depression. In M. DesMeules, D. Stewart, A. Kazanjian, H. McLean, J. Payne, & B. Vissandjee (Eds.) *Women's health surveillance report: A multi-dimensional look at the health of Canadian women.* Ottawa, ON: Canadian Institute for Health Information. Retrieved from **http://www.phac-aspc.gc.ca/publicat/whsr-rssf/pdf/CPHI_WomensHealth_e.pdf**

[8] Canadian Mental Health Association. (undated). *Depression.* Toronto, ON: Canadian Mental Health Association. Retrieved from **http://www.toronto.cmha.ca/ct_about_mi/depression.asp**

[9] Perlman, C., Neufeld, E., Martin, L., Goy, M., & Hirdes, J.P. (2011). *Suicide risk assessment inventory: A resource guide for Canadian health care organizations.* Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute. Retrieved from **http://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf**

[10] Duff, D.F. (2009). Self-injury. *Psychiatry, 8*(7), 237-240.

[11] Shaw, S.H. (2002). Shifting conversations on girls' and women's self injury: An analysis of the clinical literature in historical context. *Feminism & Psychology, 12*(2), 191-219. doi: 10.1177/0959353502012002010.

[12] Gask, L., & Morriss, R. (2009). Assessment and immediate management of people at risk of harming themselves. *Psychiatry, 8*(7):241-245. doi: 10.1016/j.mppsy.2009.04.007.

[13] McAllister, M. (2003). Multiple meanings of self harm: A critical review. *International Journal of Mental Health Nursing, 12*(3), 177-185. doi: 10.1046/j.1440-0979.2003.00287.x.

[14] Perlman, C., Neufeld, E., Martin, L., Goy, M., & Hirdes, J.P. (2011). Suicide risk assessment inventory: A resource guide for Canadian health care organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute. Retrieved from **http://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf**

[15] Perlman, C., Neufeld, E., Martin, L., Goy, M., & Hirdes, J.P. (2011). Suicide risk assessment inventory: A resource guide for Canadian health care organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute. Retrieved from **http://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf**

[16] Perlman, C., Neufeld, E., Martin, L., Goy, M., & Hirdes, J.P. (2011). Suicide risk assessment inventory: A resource guide for Canadian health care organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute. Retrieved from **http://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf**

[17] Brown, P.J., & Wolfe, J. (1994). Substance abuse and posttraumatic stress disorder comorbidity. *Drug and Alcohol Dependence, 35*, 51-59.

[18] Coalescing on Women and Substance Use: Linking Research, Practice, and Policy. (undated). *Discussing substance use with women and offering programming that addresses violence, substance use, and related health and social issues (information sheet 4).* Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Retrieved from **http://www.coalescing-vc.org/virtualLearning/section1/documents/Violence_Sheet%204_CCSA_final.pdf**.

[19] Ewing, J.A. (1984). Detecting alcoholism: The CAGE questionnaire. *The Journal of the American Medical Association, 252*(14), 1905-1907. doi:10.1001/jama.1984.03350140051025.

[20] Bradley, K.A., Boyd-Wickizer, J., Powell, S.H., & Burman, M.L. (1998). Alcohol screening questionnaires in women: A critical review. *Journal of the American Medical Association, 280*(2), 166-171. doi: 10.1001/jama.280.2.166.

[21] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders.* Ottawa, ON: Health Canada. Retrieved from **http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/bp_disorder-mp_concomitants/bp_concurrent_mental_health-eng.pdf**

[22] Collins, S.E., Clifasefi, S.L., Logan, D.E., Samples, L.S., Somers, J.M., & Marlatt, G.A. (2012). Overview of harm reduction, In G.A. Marlatt, M.E. Larimer, & K. Witkiewitz (Eds.) *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*.

[23] Miller, W.R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy, 37*(2), 129-140. doi: 10.1017/S1352465809005128.

[24] Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change (2nd ed.)*. New York, NY: The Guilford Press.

[25] Cross, P. (2012). *Fact sheet: Duty to report*. Toronto, ON: Springtide Resources.

[26] Canadian Mental Health Association. (undated). *The mental health act*. Toronto, ON: Canadian Mental Health Association. Retrieved from **http://www.toronto.cmha.ca/ct_about_mi/mh_act.asp**.

Appendix 4-1

Nellie's Shelter: Women, Drug Use and Harm Reduction Policy October 27, 2004 Approved by Board

Principles

Nellie's views Harm Reduction as a spectrum of strategies that reduce the negative health, social and economic consequences of drug use for women, families and communities. It does not focus on abstinence as an ideal goal, but rather on safe use for both the user and the broader community. While drug use does have negative health consequences, it is the conditions and equipment used that cause far more damage to a user's and to a community's health and well-being.

We understand women's experience of violence and exploitation as a factor in women's drug use. Historically, drugs and the conditions surrounding drug use have been used as a tool of colonization, in particular against Aboriginal and African communities. Still today, poverty, classism, racism, social isolation, sex and gender based discrimination, past trauma and other forms of oppression affect drug use as well as the degree to which a woman can access treatment or harm reduction programs and services. Women drug users have less access to safe, affordable housing, income, employment and educational training, medical care and safe shelter.

Legal and illegal drug use is a global and local reality. Nellie's recognizes this fact and supports the decriminalization of drug use in an effort to minimize the harmful effects of drug use. The questions of legalization and decriminalization are very complex. We understand decriminalization to be a social policy and legislation approach that supports the view of drug use/addiction and users to be dealt with as a health rather than a criminal issue. Harm reduction is a more feasible strategy than attempting to eliminate drug use completely. An emphasis on the creation of a "drug free society" in fact increases drug related harm by making it challenging, if not impossible, to access safe substances and paraphernalia.

Drug use is complex and can include, often at different periods in a woman's life, periods of severe use to total abstinence. Nellie's believes that the cessation of all drug use is not a criteria for successful drug intervention and policy. Rather, success is determined by an enhanced quality of individual and community life and well-being.

Current drug policies exacerbate the impact that long term drug use may have on a user's family, housing, employment and health. Illegal drug users have traditionally been defined as either medical patients or criminals, rather than community and family members. There is an interrelation between punishment for illegal drug use and gender, race and economic status. The majority of women prosecuted for using illegal substances are low income and of colour, despite the fact that rates of illegal drug use is similar across race and class lines.

There is a lack of gender based treatment programs for women who choose them. The programs that exist for women are all abstinence based and there are few harm reduction programs. As well, there is a striking absence of research regarding the unique experience of women drug users and women and harm reduction services. This invisibility reveals the sexism inherent in addictions services and research.

Women who use illegal substances are excluded from society and are subjected to stereotypes and moral judgements. Racialized women who are also drug users face increased discrimination, stigma and exclusion based on drug use as well as on race and gender.

We understand that women drug users live in constant fear that their children will be apprehended by a range of services intended to support them. Often, children of women drug users are apprehended not because of the quality of a woman's parenting, but because of stereotypes about drug users, discriminatory attitudes and moral judgements about drug use. A risk assessment should include a risk assessment that assesses parenting issues and looks at the provision of parenting supports and/or alternatives. For children, the trauma of separation has negative impacts. Nellie's agrees that a coordinated approach to supporting women drug users in continuing to parent in an effective way, is critical to the health and well-being of their children.

It is imperative that services and programs are delivered to those who use in a manner that is non-judgmental and non-coercive and in a feminist, anti-racist anti-oppression framework. Women who currently use or who have a history of drug use should have a genuine voice in the creation and delivery of programs and services designed to serve them. We believe that all women are valued members of society and have the right to full participation in society. The punitive nature of drug laws deny the rights of women and communities.

Position

Nellie's analysis and framework is shaped by a feminist, anti-racist, anti-oppression approach, which means we understand society as being fundamentally based on patriarchal social relations as well as by racism and multiple other forms of oppression on the basis of class, age, sexual orientation, disability, gender identification, colour, place of origin, ethnic origin, citizenship, religion, political affiliation, record of offences, marital status, family status, life experiences and appearance. Our analysis also highlights the complexity of dominant power relations, including the ways these multiple forms of oppression work together to create differential impacts and diverse needs and issues for different groups of women.

Systemic racism, discrimination, and oppression based on race, class, sexual orientation, gender identification, age, and ability must be addressed as part of an integrated approach to addressing women, drug use and harm reduction.

There has never been a society that has been drug-free. Our society legitimizes some drug use, such as alcohol and tobacco, but demonizes others, such as crack and heroin. At different points in history, some drugs, such as cocaine, have been deemed acceptable, while others, such as alcohol, unacceptable. This validates those who use legal drugs and criminalizes those who use illegal ones differentially. While we do not attempt to minimize or ignore the real and tragic harm associated with any drug use, we believe women have the right to use safely. The harm that drugs may cause should be reduced, but benefits should also be recognized and maximized. Further, some drugs, such as marijuana, are less harmful than others and even have medicinal benefits, whereas a drug such as alcohol is far more dangerous yet is socially and legally sanctioned. Drug programs should be focused on the relative harmfulness of drugs, legal and illegal, to society.

Women who use illegal drugs or those who are considering using have a right to unbiased, non-judgmental, reliable information about the substances they are using or contemplating using. Women who use have a right to access shelters that allow for use and do not demand abstinence.

There are benefits to drug use, however there may also be negative consequences as a result of using illicit drugs. Some of these consequences may be attributable to the effects of the drug itself on the body and mind. More often, however, drug related harm is the result of the social, economic, legal, cultural and political factors that shape the way illegal drugs are made available, and the conditions under which they are used. Punitive laws, social policies and the intense social stigmatization of and discrimination against illicit drug users help create unsafe conditions. The health and social consequences resulting from women being forced to use in unsafe environments,

use dirty water, share needles, use makeshift pipes, or not be confident in the purity of the substance they're using, are far more damaging than the consequences of drug use itself. HIV, Hepatitis, overdose, etc. are a result of unsafe use and conditions rather than from drug use itself. The exclusion of women drug users from the community nurtures alienation, isolation, low self-confidence and self-esteem, dependence, fear and anger.

Drug treatment and prevention policy is rooted in criminal law and incarceration, however this approach helps few women drug users. Women drug users and their communities are criminalized as a result of current drug control measures. Women and communities, particularly those of colour and the First Nations community, are greatly impacted by arrest and incarceration resulting from these measures, but also by the related issues of infectious disease, poor housing, unemployment, violence and poverty. The decriminalization of drugs would help ensure access to safe paraphernalia and substances that have been tested for purity or harmful additives.

Harm reduction services that are geared specifically for sex trade workers offer those who use drugs the ability to work in that environment in a safer way. Without harm reduction services for sex workers, women have less control over their working environment and are more vulnerable. Sex trade workers are often forced by the threat of violence to accept unprotected sex and unsafe working conditions, which is especially significant where sex and drugs are "traded".

There is a clear interrelation between drug policy and reproductive rights. The dislike, distrust and moral judgement of illegal drug users increases when the illegal drug user is a pregnant woman, however punitive approaches ultimately undermine the health and well-being of a woman and her fetus. The threat of criminal prosecution deter women from seeking prenatal care, and discourage women from communicating their drug use to health care professionals who need the information in order to provide appropriate medical care. The primary reason pregnant women drug users do not seek prenatal care is fear of being turned in to authorities and ultimately loosing their children. While we agree that pregnant women should engage in activities that promote the birth of healthy children, we view a woman's substance use as a reflection of complex factors, such as poverty, violence and homelessness, which are best addressed in a public health context rather than in a criminal one that is rooted in moral judgement.

Current drug policies and laws are based on oppressive moral assumptions about women which has resulted in incarceration of women users and the forming of pregnant women under Mental Health legislation as a "danger to self or others". Children of women who use drugs can be apprehended because of a single positive drug test, however substance use is not evidence that a woman will mistreat her child after birth or is unable to parent. Poor and racialized women are particularly vulnerable to losing their children, even though white women of all socioeconomic groups use illegal drugs at the same rates of women of colour. While children should be protected from a mother who is unable to parent, a positive drug test should not be used as an evaluation of parenting ability. The evaluation must be based on a risk assessment which is based on multiple factors and criteria which measure mother's ability to protect, nurture and care for her children and the negative impact on children. It is true that children exposed prenatally to some legal and illegal drugs do experience some adverse short or long term health consequences and that this varies based on a number of factors including both substance and duration. We know that poverty, violence and homelessness have both short term and long term health consequences for women and their children as a result of lack of access to quality prenatal care and adequate nutrition.

Harm reduction services recognize the vital need for prenatal care and counselling for past trauma for all pregnant women and provide it in a non-judgmental context.

Harm reduction services such as safe injection sites reduce the mortality rates and costs associated with

drug overdoses, reduce diseases such as HIV, Hepatitis B and Hepatitis C, enhance access for women who inject drugs to drug treatment, health and social welfare services, reduce the public problems associated with drug use such as using in parks, streets and other public places, and discarded needle syringes and other injecting paraphernalia. Safe injection rooms should be legally sanctioned and classified as medical establishments to provide legal protection to clients and staff. Facilities should provide sterile equipment, information about drugs and health care, treatment referrals, access to medical staff and counselling.

Strategies for Change

Board, staff and clients in service will be active in the strategies for change. The work will be based on our organization's mission and informed by the work we do with women and children in our programs and services.

We will work with other women's groups in coalition and partnership at the Municipal, Provincial and Federal level to address the issues of women and harm reduction.

We will maintain membership in women's organizations and other organizations that support harm reduction services.

We will maintain membership in children's justice organizations that support equality and harm reduction programs and services for women.

We will work across sectors in the areas of community education and advocacy to change the social and economic conditions that contribute to drug related harm.

We will ensure that in all the harm reduction work in which we are involved, we bring to the discussion a feminist, anti-racist, anti-oppression framework for action. In addition, we will remain actively involved in anti-racist, anti-oppression work.

We will actively lobby the Municipal, Provincial and Federal governments to provide proper funding for harm reduction programs and services.

The methods we will use to effect social change may include participation in coalitions, public education and media campaigns, and direct political action such as participation in protests and rallies, deputations, complaints and refusal to participate in oppressive government programs.

We will respond with programs and services that meet the needs of the diversity of women and children who have experienced poverty, violence and oppression. Programs and services that address the needs of women and strengthen their economic, social and health position will enable them to protect and support themselves and their children.

We will continue to identify the changing realities and oppression in all systems and laws through inclusive consultation with the women and children we serve, to identify the areas where they are failing women and children, and to advocate for changes that will serve the goal of ending drug related harm in the lives of women and children.

Policy References

1. The Centre for Harm Reduction, What is Harm Reduction, **www.chr.asn.au**, 2003.
2. The Centre for Harm Reduction, The Need for Harm Reduction, **www.chr.asn.au**, 2003.
3. Open Society Institute, Drug Use and Pregnancy in the United States, **www.soros.org/initiatives/ihrd/events/drugusepregnanacy**, 2003.
4. Drug Policy Alliance, Punishing Women for their Behavior During Pregnancy: An Approach that Undermines Women's Health and Children's Interests: Part I, **www.dpf.org**, 2003.
5. Drug Policy Alliance, Governmental Responses to Pregnant Women who use Alcohol or Other Drugs, Part 1, **www.dpf.org**, 2003.
6. Drug Policy Alliance, Defunding the Poor: The Impact of Lost Access to Subsidized Methadone Maintenance Treatment on Women Injection Drug Users, **www.dpf.org**, 2003.
7. Drug Policy Alliance, The War on Drugs is a War on Women of Color, **www.dpf.org**, 2003.
8. Drug Policy Alliance, War on Drugs, War on Women, **www.dpf.org**, 2003.
9. Drug Policy Alliance, Arresting Pregnant Women for Drug Use, **www.dpf.org**, 2003.
10. Drug Policy Alliance, Women and Pregnancy, **www.dpf.org**, 2003.
11. Drug Policy Alliance, Safer Injection Rooms, **www.dpf.org**, 2003.
12. Uniting Care, Sydney Medically Supervised Injection Centre, **www.unitingcare.org.au**, Wednesday, January 28, 2004.
13. International Harm Reduction Association, Discarded Used Injection Equipment, **www.ihra.net**.
14. Harm Reduction Communication, The Case Management Connection, **www.harmreduction.org/newsletter.html**, Fall 1997.
15. *Four Points About Drug Legalization*, Criminal Justice Ethics, Winter 2003:22,1:Research Library, Douglas Husak
16. *Epilogue: What are Good Drugs Anyway*, Criminal Justice Ethics, Winter 2003:22,1:Research Library, Lester H. Hunt
17. *On the Decriminalization of Drugs*, Criminal Justice Ethics, Winter 2003:22,1:Research Library, George Sher
18. An Extensional Approach to Drug Legalization, et Cterea:Summer 2003 Research Library, Martin H. Levinson
19. Commonsense Drug Policy, Foreign Affairs, Jan/Feb 1998;77,1:ABI/INFORM Global, Ethan A. Nadelmann

Appendix 4-2

Creating a Safety Plan

Creating a Safety Plan

PCAWA

PEEL COMMITTEE AGAINST WOMAN ABUSE

Developed by:

The Peel Committee Against Woman Abuse

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April 2006

Many women have escaped and survived abusive situations. This information package was put together by women who have survived and offer their advice to you.

To order more copies of this booklet, please contact:
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INTRODUCTION

It is important to know that although you do not have control over your (ex) partner's violence, it is possible to increase your own, as well as your children's, safety when being subjected to this abuse. Creating a safety plan involves identifying action steps to increase your safety, and to prepare in advance for the possibility of further violence. This information package offers many suggestions and ideas that we hope you will find useful. However, don't try to do everything right away. Take it a step at a time, and start with the ideas that seem most doable for you.

In creating a safety plan it is important to remember that:

- ☑ Although you cannot control your (ex) partner's violence, it may be possible to increase your own and your children's safety.
- ☑ A safety plan is needed whenever the possibility of abuse is identified.
- ☑ This safety plan information is specifically designed for actions that you can take.
- ☑ This safety plan information also includes actions you can take to increase your children's safety.
- ☑ It is important to become familiar with and to review and/or revise your safety plan regularly. Abusive situations and risk factors can change quickly.

I. AN EMERGENCY ESCAPE PLAN

The **Emergency Escape Plan** focuses on the things you can do in advance to be better prepared in case you have to leave an abusive situation very quickly.

The following is a list of items you should try to set aside and hide in a safe place (e.g. at a friend's or family member's home, with your lawyer, in a safety deposit box):

a) Take a photocopy of the following items and store in a safe place, away from the originals. Hide the originals someplace else, if you can.

- ❑ passports, birth certificates, immigration papers, for all family members
- ❑ school and vaccination records
- ❑ driver's license and registration
- ❑ medications, prescriptions, medical records for all family members
- ❑ welfare identification
- ❑ work permits
- ❑ divorce papers, custody documentation, court orders, restraining orders, marriage certificate
- ❑ lease/rental agreement, house deed, mortgage payment book
- ❑ bank books
- ❑ insurance papers
- ❑ address/telephone book
- ❑ picture of spouse/partner
- ❑ health cards for yourself and family members
- ❑ all cards you normally use e.g. credit cards, bank cards, phone, Social Insurance

b) Try to keep all the cards you normally use in your wallet:

- ❑ Social insurance cards
- ❑ Charge cards
- ❑ Phone card
- ❑ Banking cards
- ❑ Health cards

c) Try to keep your wallet and purse handy, and containing the following:

- ❑ car/house/office keys
- ❑ checkbook, bank books/statements
- ❑ driver's license, registration, insurance
- ❑ address/telephone book
- ❑ picture of spouse/partner
- ❑ emergency money (in cash) hidden away

d) Keep the following items handy, so you can grab them quickly:

- ❑ emergency suitcase with immediate needs
- ❑ special toys, comforts for children
- ❑ jewelry
- ❑ small saleable objects
- ❑ items of special sentimental value
- ❑ a list of other items you would like to take if you get a chance to come back to your home later
- ❑ Open a bank account in your own name and arrange that no bank statements or other calls be made to you. Or, arrange that mail be sent to a friend or family member.
- ❑ Save and set aside as much money as you can - out of groceries if necessary.
- ❑ Set aside, in a place you can get to quickly, $10 to $15 for cab fare, and quarters for the telephone.
- ❑ Plan your emergency exits.
- ❑ Plan and rehearse the steps you will take if you have to leave quickly, and learn them well.
- ❑ Hide extra clothing, house keys, car keys, money, etc. at a friend's house.
- ❑ Keep emergency suitcase packed or handy/ready to pack quickly.
- ❑ Consider getting a safety deposit box at a bank that your partner does not go to.

The Police will bring you back to the home later, to remove additional personal belongings, if it is arranged through the local division. Take the items listed above as well as anything else that is important to you or your children.

When you leave, take the children if you can. If you try to get them later, the police cannot help you remove them from their other parent unless you have a valid court order.

II. CREATING A SAFER ENVIRONMENT

There are many things a woman can do to increase her safety. It may not be possible to do everything at once, but safety measures can be added step by step. Here are a few suggestions:

1. AT HOME

If you are living with your abusive partner/spouse:

- ❑ Get your Emergency Escape Plan in order and review it often.
- ❑ Create a telephone list with numbers of local police, nearest women's shelter, assaulted women's help line, crisis help line, family members, counselors, children's friends.
- ❑ Make arrangements with friends or family so that you can stay with them if necessary.
- ❑ Try to predict the next likely violent episode and make plans for the children to be sent to friends, family etc. (Try to anticipate his "cycle," e.g. when there is a full moon.)
- ❑ Teach the children to let you know when someone is at the door, before answering the door.
- ❑ Teach your children how to use the telephone (and your cellular phone, if you have one) to contact the police and the fire department.
- ❑ Create a code word with your children and/or friends so they know to call for help.
- ❑ Teach your children how to make a collect call to you and to a special friend if your partner takes the children.
- ❑ Plan your emergency exits, teach your children and know them well.
- ❑ Teach your children their own Safety Plan (See page 114).

If you are not living with your abusive partner/spouse:

- ❑ Change the locks on the doors and windows. Install a peephole in the door. Change the locks on your garage and mailbox.
- ❑ Teach your children to tell you if someone is at the door and to not answer the door themselves.
- ❑ Keep your restraining order near you at all times.
- ❑ Make sure that the school, day care, and police have a copy of all court orders, including restraining orders, custody and access orders, as well as a picture of the abusive partner.
- ❑ If possible, try to predict the next likely violent incident and be prepared.
- ❑ If you have call display on your phone, be careful about who can get access to the store numbers (example, last number dialed, etc.).
- ❑ Have your telephone number unpublished, as it is harder to track than when it is unlisted. Block your number when calling out.

- ❑ Consider getting a cellular phone and preprogram numbers of people to call.
- ❑ Contact your local Victim Services to inquire about your eligibility for the Supportlink / D.V.E.R.S. emergency response system program.
- ❑ Consider moving your furniture around differently as this is something your partner may not anticipate, and cause him/her to bump into it and give you warning that he/she is in the house. Also put your kitchen utensils and knife block in the cupboards so they are not as accessible.
- ❑ If you live in an apartment, check the floor clearly when getting off the elevator. Look in mirrors and be aware of doorways in hallways. Speak to security, or make an anonymous call, requesting safety in your building.
- ❑ Purchase rope ladders to be used for escape from upper floors.
- ❑ If you have a balcony, consider putting wire around it.
- ❑ Replace wooden doors with steel/metal doors if possible.
- ❑ Install smoke detectors and fire extinguishers for each floor.
- ❑ Consider the advantages of getting a guard dog.
- ❑ Install an outside lighting system that lights up when a person is coming close to your house.
- ❑ Do whatever you can to install security systems, including additional locks, window bars, poles to wedge against doors, an electronic system, etc. – anything to provide added security.

2. IN THE NEIGHBOURHOOD

- ❑ Tell your neighbours that you would like them to call the police if they hear a fight or screaming in your home.
- ❑ Tell people who take care of your children which people have permission to pick up your children.
- ❑ Tell people in your neighbourhood that your partner no longer lives with you, and they should call the police if he/she is seen near your home. You may wish to give them a photo and description of him/her and of their car.
- ❑ Ask your neighbours to look after your children in an emergency.
- ❑ Hide clothing and your Emergency Escape Plan items at a neighbour's house.
- ❑ Use different grocery stores and shopping malls, and shop at hours that are different from when you were living with your abusive partner.
- ❑ Use a different bank or branch, and take care of your banking at hours different from those you used with your abusive partner.
- ❑ Change your doctor, dentist and other professional services you would normally use.
- ❑ Do not put your name in your apartment building directory.

3. AT WORK

Each woman must decide for herself if and/or when she will tell others that her partner is abusive and that she may be at risk. Friends, family and co-workers may be able to help protect women. However, each woman should consider carefully which people to ask for help. If you are comfortable, you may choose to do any or all of the following:

- ❑ Tell your boss, the security supervisor, and other key people or friends at work about your situation.
- ❑ Ask to have your calls screened at work. It would also help to have these calls documented.
- ❑ Discuss the possibility of having your employer call the police if you are in danger from your (ex) partner.

When arriving or leaving work:

- ❑ let someone know when you'll be home.
- ❑ carry your keys in your hands.
- ❑ get a remote or keyless entry car door opener.
- ❑ walk with someone to your car.
- ❑ scan the parking lot.
- ❑ walk around your car, look under the hood and check if anything has been tampered with and check brakes. Remember to keep your car seats forward, so you know if someone is hiding in the car.
- ❑ if your partner is following you, drive to a place where there are people to support you, e.g. a friend's house, police station.
- ❑ if you have underground parking, consider parking across the street.
- ❑ keep a sign in your car saying "call police".
- ❑ if you are walking, take a route that is populated.
- ❑ change the patterns of when you arrive and leave work and the routes you take home.
- ❑ if you see your partner on the street, try to get to a public place, e.g. a store.
- ❑ if you see your partner on the street, call attention to yourself and request help.

III. AN EMOTIONAL SAFETY PLAN

The experience of being abused and verbally degraded by partners is usually exhausting and emotionally draining. The process of surviving and building a new life requires much courage, and incredible energy. To conserve your emotional energy, and to support yourself in hard emotional times, there are a number of things you can do:

- ❑ Attend as many Crisis Counselling group sessions as you can.
- ❑ Become involved in community activities to reduce feeling isolated.
- ❑ Take a part-time job to reduce isolation and to improve your finances.
- ❑ Enroll in school to increase your skills.
- ❑ Join support groups of other women to gain support and strengthen your relationships with other people.
- ❑ Take time for yourself to read, meditate, play music, etc.
- ❑ Spend time with people who make you feel good and provide support.
- ❑ Take part in social activities, e.g. movie, dinner, exercise.
- ❑ Take care of your sleep and nutritional needs.
- ❑ Keep your Client Profile up to date to help you feel prepared for upcoming events.
- ❑ Keep a personal journal to write about your feelings, especially when you are feeling low or vulnerable. Keep it in a safe place or burn it.
- ❑ Take time to prepare yourself emotionally before entering stressful situations like talking with your partner, meeting with lawyers, or attending court.
- ❑ Try not to overbook yourself - limit yourself to one appointment per day to reduce stress.
- ❑ Be creative and do whatever makes you feel good.
- ❑ Write something positive about yourself everyday - your own personal affirmations.
- ❑ Do not find your comfort in excessive use of alcohol or food - it only serves to increase your depression.
- ❑ Avoid excessive shopping and impulse buying.
- ❑ Join a health club or start an exercise program. It will increase your energy level and increase your sense of well being.
- ❑ It's OK to feel angry, but find positive and constructive ways to express your anger.
- ❑ Remember that you are the most important person to take care of right now.

IV. A CHILD'S SAFETY PLAN

This plan was developed to help mothers teach their children some basic safety planning. It is based on the belief that the most important thing that children can do for their mothers and their families is to get away from the area of violence! They cannot stop the abuse, although they often try by distracting the abuser or directly interfering in the abusive episode. It is important to tell the child that the best and most important thing for them to do is keep themselves safe.

Children who experience woman abuse can be profoundly affected. It is very traumatic for them to be faced with violence directed at them or at someone they love. Personal safety and safety planning are extremely important and necessary for children whose families are experiencing violence. Children should learn ways to protect themselves. There are several ways to help you develop a safety plan with your children.

- ❑ Have your child pick a safe room/place in the house, preferably with a lock on the door and a phone. The first step of any plan is for the children to get out of the room where the abuse is occurring.
- ❑ Stress the importance of being safe, and that it is not the child's responsibility to make sure that his/her mother is safe.
- ❑ Teach your children how to call for help. It is important that children know they should not use a phone that is in view of the abuser. This puts them at risk. Talk to your children about using a neighbour's phone or a pay phone if they are unable to use a phone at home. If you have a cell phone, teach your children how to use it.
- ❑ Teach them how to contact police at the emergency number.
- ❑ Ensure that the children know their full name and address (rural children need to know their Concession and Lot #).
- ❑ Rehearse what your child/children will say when they call for help.

For example:

Dial 911.

An operator will answer: ***"Police, Fire, Ambulance."***

Your child says: ***Police.***

Then your child says:

My name is _____.
I am ____ years old.
I need help. Send the police.
Someone is hurting my mom.
The address here is _____.
The phone number here is _____.

- ❑ It is important for children to leave the phone off the hook after they are done talking. The police may call the number back if they hang up, which could create a dangerous situation for yourself and your child/children.
- ❑ Pick a safe place to meet your children, out of the home, after the situation is safe for you and for them (so you can easily find each other).
- ❑ Teach your children the safest route to the planned place of safety for them.

V. DURING A VIOLENT INCIDENT

Women cannot always avoid violent incidents. However, in order to increase your safety, here are some things you can do:

- ❑ Remind yourself that you have an Emergency Escape Plan, and go over it in your mind.
- ❑ Start to position yourself to get out quickly or near a phone so you can call 911, if necessary.
- ❑ Try to move to a space where the risk is the lowest. (Try to avoid arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door.
- ❑ Use your code word with your children so they can call for help.
- ❑ Use your judgement and intuition - if the situation is very serious, you can agree with your partner or give him/her what he/she wants to calm him/her down. You have to protect yourself until you are out of danger.
- ❑ When, or after, you have been assaulted, call the police at 911 if you can. Tell them you have been assaulted by a man/woman, (don't say your husband/partner), and leave the phone off the hook after your call.
- ❑ Make as much noise as possible (set off the fire alarm, break things, turn up the stereo or TV) – so that neighbours may call the police for you.

RESOURCES FOR ABUSED WOMEN IN PEEL

(all area codes are 905, unless otherwise listed)

POLICE

Peel Regional Police	
Emergency	911
Non Emergency	453-3311
Caledon O.P.P.	1-888-310-1122
Trillium Health Centre - Sexual Assault & Domestic Violence Services (document and treat injuries sustained as a result of domestic violence)	848-7600

24 HOUR CRISIS LINES

Assaulted Women's Help Line (**www.awhl.org**)	1-866-863-0511
TTY	1-866-863-7868
Caledon/Dufferin Victim Services	905-951-3838 or 1-888-743-6496
Children's Aid Society of Peel	363-6133
Family Transition Place	1-800-265-9178
Interim Place South	403-0864
Interim Place North	676-8515
Salvation Army Family Life Resource Centre	451-6108
Sexual Assault / Rape Crisis Centre of Peel	273-9442
Sexual Assault / Rape Crisis Centre	1-800-810-0180
Victim Services of Peel	568-1068

SHELTERS

Central Intake Number	416-397-5637
Family Transition Place (Orangeville)	1-800-265-9178
Interim Place South	403-0864
Interim Place North	676-8515
Salvation Army Family Life Resource Centre	451-4115
Armagh (second stage housing)	855-0299

www.shelternet.ca

FINANCIAL ASSISTANCE

Social Assistance	793-9200
Peel Housing	453-1300
Salvation Army Family & Community Services	451-8840

LEGAL SERVICES

North Peel & Dufferin Community Legal Services	455-0160
Mississauga Community Legal Services	896-2052
Legal Aid Ontario	453-1723
Victim Witness Assistance Program	
(criminal court support services)	456-4797
India Rainbow Community Services of Peel (Legal Clinic)	275-2369
Victim Services of Peel	
(criminal court support at Bail Hearing)	568-1068

SUPPORT SERVICES FOR WOMEN

African Community Services	460-9514
Catholic Cross-Cultural Services	
Brampton	457-7740 ext. 115
Mississauga	273-4140 ext. 109
Catholic Family Services of Peel-Dufferin	1-888-940-0584
Brampton	450-1608
Mississauga	897-1644
HEAL Network	450-1608 ext. 118
Family Services of Peel	
Centralized Intake	453-5775
Brampton	453-7890
Mississauga	270-2250
India Rainbow Community Services	
Brampton	454-2598
Mississauga	275-2369
Malton Neighbourhood Services	677-6270
Muslim Community Services	
Brampton	790-1910
Mississauga	828-1328
Punjabi Community Health Centre	
Mississauga	301-2978
Salvation Army Women's Counselling Centre	820-8984
United Achievers Community Services	455-6789
Vita Centre of Peel	858-0329

FOODBANKS

Foodpath Foodbank (Mississauga)	270-5589
The Salvation Army Foodbank	
Brampton	451-8840
Mississauga	279-2526

(all area codes are 905, unless otherwise listed)

PERSONAL NOTES

SECTION FIVE:
COLLABORATING ACROSS DISCIPLINES, SECTORS AND LOCATIONS

I don't think there has been a coordination of services regarding mental health and substance abuse in our region. There's been a lot of VAW collaboration in terms of settlement agencies and court services and all the services involved in VAW, but I don't think that they have ever sat down at the table with management centres or treatment programs and — or addiction referral services and actually said "okay, how do we coordinate, how do we make these referrals more effective, how can you — how can we work together to ensure we're not losing this woman?
(SHELTER FOCUS GROUP)

WHY COLLABORATE?

"Because an interdisciplinary collaboration brings together people with different backgrounds, we can benefit from a bigger and more diverse set of solutions."[1]

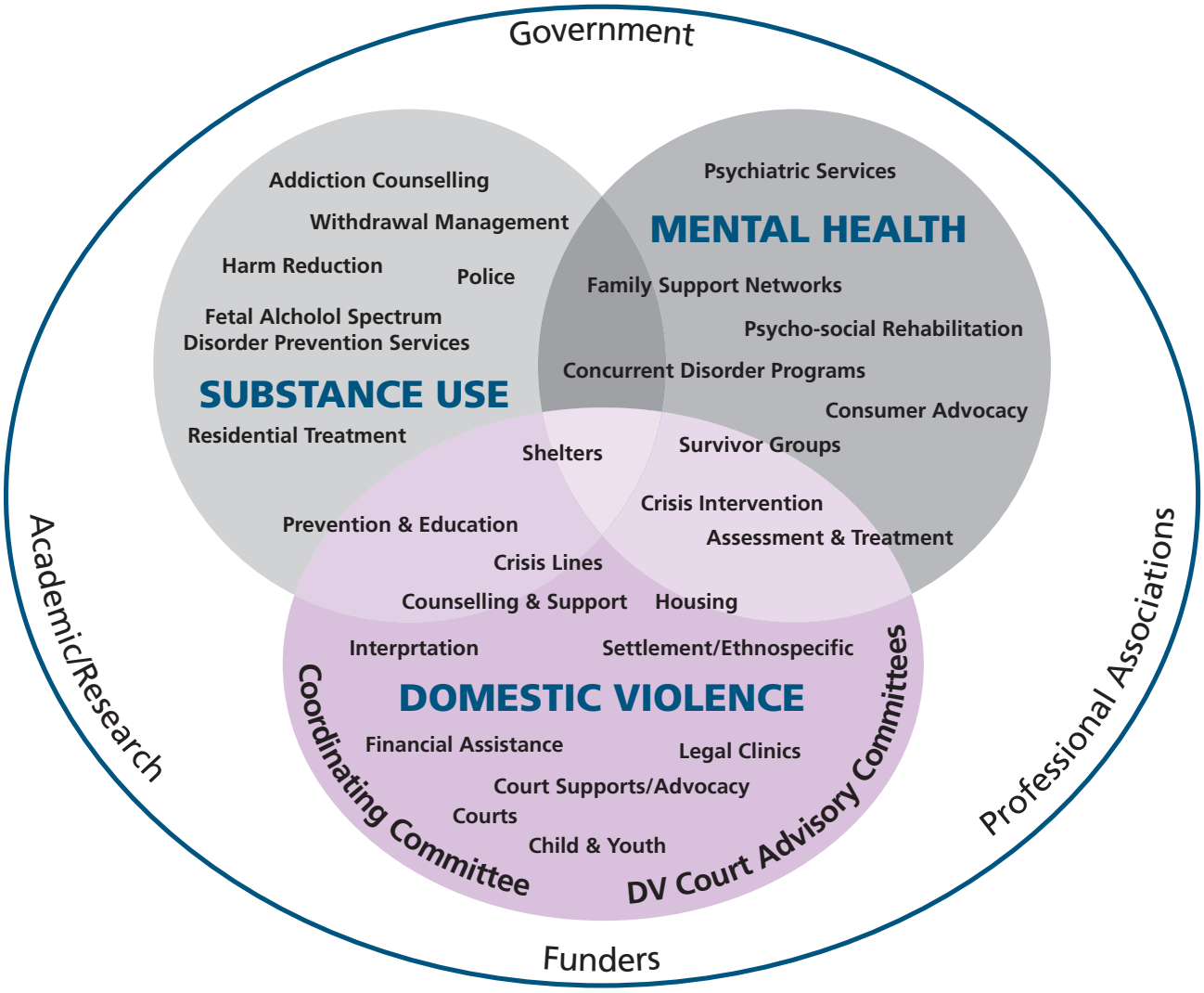
On their own, DV, mental health and substance use are complex issues. When they intersect it becomes not simply a more complicated problem but the creation of a challenge of a different kind. The result is often a tightly spun web involving many elements, each one magnifying the impact of the other.

Understanding and supporting individuals who are experiencing DV, mental health and substance use problems demands a comprehensive approach supported by a multidisciplinary and multisectoral collaboration. Involving a wide range of partners with expertise in different aspects of the problem is essential to a holistic understanding, analysis, definition and application of good practices.

Complex problems involve a wide range of factors that interact with one another to generate a constantly shifting set of issues and challenges. As a result, they can be addressed effectively only when an equally wide range of partners, each engaged with different aspects of the issue, work together to adjust and re-adjust how they affect one another through the decisions and actions they take.[2] Such problems have a number of commonalities:

- They usually involve multiple sectors and stakeholders
- Are difficult to define and there is rarely consensus about their root causes
- Are interdependent and often have multiple causes
- Do not fit neatly into any boundaries
- Defy conventional approaches to problem solving and are beyond the capacity of any one organization or sector to respond effectively

Complex social issues require a different approach in order to come up with responses and interventions that are flexible and comprehensive. Collaboration is a promising practice in developing effective responses to individuals experiencing DV, mental health and substance use problems, however collaboration requires that service providers and sectors adjust their way of thinking and approach. It demands the establishment of new systems and processes within each organization and sector to build and maintain collaborative efforts. Recognizing that social issues do not live and breathe in isolation of each other is a critical first step. The next step is to ask 'what is needed to establish and support collaborative practice as our preferred way of doing business?'



Collaboration has core characteristics that challenge conventional individual and organizational thinking and practice. These characteristics include:

- trusting relationships
- a holistic problem perspective
- pooling of resources
- harnessing collective synergies and expanded skills

There is a three-tiered level of responsibility for providing options and alternatives appropriate to a woman's circumstances and needs. The individual service provider has the responsibility of engaging the woman in identifying her needs, completing an assessment and offering the necessary supports either directly or by way of referral. The service agency and service community have the responsibility of ensuring that such options and alternatives are available and accessible.

By bringing together a diverse set of stakeholders with differing perspectives, collaborative approaches enable a more holistic view of a complex problem. Using macro analysis and inclusive brainstorming allows for a better understanding of the interconnections among DV, mental health and substance use problems, and how they impact each other. It enhances the capacity of participating service providers at an individual and organizational level by expanding the skill set brought to the collaborative, as well as shared learning and the experience of working together. The actual process of collaboration is the real

benefit as it creates innovative responses and generates outcomes not initially contemplated. In other words in working together more can be achieved than working in isolation.[4]

Something To Think About

What specific benefits/advantages might the women in your community realize as a result of cross-sectoral collaboration?

BUILDING PARTNERSHIPS

The concept of collaboration is gaining growing acceptance as a best practice for bringing together professionals and sectors with differing perspectives and interests. While the value of working together rather than continuing to operate from individual silos is recognized, the actual "doing" of it remains difficult. Collaboration is complex. The process of building and sustaining relationships requires skills and ways of working that, in many cases, go against the traditional way of working. It requires:[5]

- Developing a "vision" of long term change
- Establishing a common goal or purpose
- Understanding cultures and language of different services and sectors; developing some common language
- Keeping focused on the desired outcomes and making the system more responsive to women
- Learning to listen in different ways and for different things as co-collaborators
- Enlisting allies to co-create something that everyone can "live with"
- Learning to ignore entrenched positions
- Learning how to draw out interests and create conversations
- Anticipating and managing conflict recognizing and accepting that it is a normal and essential component of moving forward
- Learning to live in the realm of "grey" when you want to turn issues into black-and-white
- Working with diverse personalities and strengths
- Self-reflection and collective critical inquiry in order to acknowledge and put aside individual and organizational agendas

It is likely that examples of collaboration exist in most communities. One approach in beginning to bring together partners from the DV, mental health and substance use communities is to identify formal and informal collaborations that already exist. For example DV groups of one sort or another exist in almost all communities across the province.

Something To Think About

What could you do to begin or strengthen partnerships among the three sectors? Are there existing collaborations or partnerships in your community that could be expanded to include representation from all three sectors?

FOUR TIPS TO BUILDING PARTNERSHIPS

1. One of the key factors in creating partnerships is building on personal relationships, particularly in the beginning of the partnership. Since trust is a key factor in any relationship, people usually work with those they know or with individuals known to one's colleagues. Successful partnerships are often those in which strong personal relationships had developed.[6] Some research suggests that "social change organizations" are often loosely organized and dependent on personal relationships.[7] While an organization and its management may stipulate or support certain partnerships, it is also possible for you to form them on your own. Once you've identified a good potential partner, you can build upon this relationship by understanding and meeting each other's needs.

2. Let the person know that you're paying attention to them and you care about what they are saying. Express your thanks and be willing to forgive mistakes knowing that you too will make mistakes.

3. Develop effective communication strategies. This may mean developing a regular "expectation exchange" whereby you agree to meet in person, communicate by telephone, or email. Sharing

memos summarizing steps taken and progress made can help build a comfort level that encourages openness. Creating a secured, shared web location to share common documents, memos, or notes can be useful. For larger groups consider developing an online hub or community of practice (a group of people bound together by a joint interest, expertise and passion).

4. Experts in women's leadership in advocacy organizations say it is important to practice open communication and be willing to consider alternate views and perspectives. As well, learn to accept and deliver critical feedback. If you don't give each other honest feedback and learn how to handle disagreements, the relationship may be jeopardized. Be sensitive to differing perspectives, values and goals held by the individual partner and their workplace or organization. Be aware and acknowledge both cognitive and emotional states in oneself and the other, appreciate what the other has to offer and consider that differences can help enrich understanding and contribute to solutions instead of being divisive.[8]

   The best informal partnerships have developed open communication and mutual trust to meet shared goals and objectives. This can serve to increase job satisfaction and provide inspiration in one's work life. Relating to individuals from other agencies can also lead to increased understanding of how other organizations, services and sectors operate, and allows a glimpse into other work cultures. A good partnership provides multiple benefits.

   However, it is also true that personal partnerships may be vulnerable to changes or challenges from within the partners' organizations. Perhaps more lasting are partnerships that become part of the organizational culture. These may be more resistant to changes in staff or leadership.[9]

STEPS TO BUILDING ORGANIZATIONAL PARTNERSHIPS

1. Before you can determine how to develop comprehensive strategies in your community, you will want to understand the context and conditions that may support or inhibit a collaborative effort. Useful insights into the potential for comprehensive partnerships can be gained by speaking to a few potential partners representing each of the three sectors, DV, mental health and substance use. These same individuals may prove to be invaluable resources in their respective sectors and as you move forward can help interest others in participating in the collaboration.

2. Consider different types of scenarios that you might encounter when working with women who are experiencing DV, mental health and substance use problems. Brainstorm both the formal and informal supports[1] that may be required to help her. Learn more about existing services both internal and external to your organization. Collect information on criteria for participation in a range of programs, costs, location, populations served, hours of operation, and additional supports provided i.e. childcare and transportation. Silos are present within organizations and sectors as well as between them. Many service providers have been surprised by the difficulty experienced in referring a woman to another program or department within the same agency.

3. Structuring the partnership should be an intentional process.[10] A review of experienced partnerships offers the following advice:
   - Ensure a broad-based, inclusive partnership. Attract appropriate participants to the collaborating table, seek partners who represent diverse disciplines, sectors, perspectives, approaches, levels of authority, and demographics.

[1] *For example: grassroots or consumer/survivor organizations*

- Don't wait for all partners to get on board before moving forward with your plans. Most partnerships expand gradually over time. As the idea gains acceptance, other partners will gradually embrace it and the size and impact of the collaborative will grow.
- Secure a commitment to collaboration. You may want to ask partner organizations to designate representatives in writing; this makes it more likely the same people will be at the table every time the group meets. It also helps move decisions along quickly if organization representatives are authorized to make commitments for their employers.
- Select a lead agency. Partnerships usually select one organization who may assume fiscal and coordinating responsibilities for the partnership. This does not mean that the lead agency should have greater influence or power than others around the table. To ensure that the lead agency does not assume undue influence or bear an unfair burden, partners must devise ways to involve all agencies and organizations in decision-making, chairing and hosting of meetings, etc.
- Establish guidelines for partner relationships. Guidelines are an important part of collaboration; the process of deciding how to work together can actually bring diverse stakeholders together. Clear guidelines and procedures can help ensure effective communication, minimize misunderstanding, and enhance collaboration among partners and agencies. Most partnerships collectively create a Memorandum of Understanding (MOU), which is approved and signed by all partners. A partnership MOU generally addresses:
  - What is the vision for and purpose of this partnership?
  - Who can be a partner?
  - What are the rights and obligations of partners?
  - How often will the group meet?
  - How will the agenda for each meeting be determined?
  - How and when will partners submit agenda items?
  - Will the position of chairperson rotate or remain stable?
  - Who will be responsible for distributing briefing materials to participants?
  - Who will record and distribute meeting minutes?
  - What sub-committee or working groups will exist and what responsibilities will they have?
  - How will decisions be made? i.e. consensus, majority rule
  - How will conflicts be identified and resolved?

4. Devise ways to share power and benefits. In a truly collaborative effort, partners relate to each other on a non-hierarchical basis, regardless of the organizational structure.[11] No single agency, organization, or individual should dominate or control the decision-making process. You can promote this balance by setting goals for your partnership that are broader than the goals of any participating agency or individual. Ensure that all partners gain equal benefit from their participation. Partnerships between unequal partners, or between unwilling partners, are severely challenged.

5. Define the focus for the partnership. The multiple stakeholders who form a partnership often work with different populations, service boundaries, funding constraints, and other factors. A collaborative partnership must collectively determine this focus. This may be broader, or more limited, than target populations served by any individual partner.

6. Create trust and a shared vision. Chances are when creating collaborations that involve DV, mental health and substance use partners, the partners may not have worked together before; they may not even know each other, or they may come from organizations or philosophical positions with histories of conflict and competition. Although diversity among partners gives multiple stakeholders a voice in the comprehensive partnership, it can also mean differing opinions about issues and the best strategies for addressing them.

A focused, effective partnership is built upon respect, sustainability, establishing a common focus and a unified vision of success. Partnerships that support open and respectful communication amongst its members will help foster trust amongst the partners.

Exploring perspectives within the group and finding common ground helps to shape a vision that will guide the partnership. A vision statement expresses the collective dreams, aspirations, and concerns regarding individuals experiencing DV, mental health and/or substance use problems. It may take some time to develop a shared vision.

Developing a shared vision is an opportunity to think creatively about traditional strategies and to imagine innovative changes; the process is open-ended and exploratory.[12] It requires partners to set aside individual and agency-specific views in favour of broader perspectives. Solicit ideas from all participants during the visioning process to promote inclusion. Write down ideas as they emerge to validate the contributions of all participants. Use a variety of approaches to capture ideas.

7. Foster inclusivity. Collaborative groups function most effectively when participants recognize, understand, and value diversity. As you establish guidelines, define an issue or community, and develop your collective vision, challenge yourself to consider the needs, unique circumstances and worldviews of diverse individuals and groups in the community. i.e. ethnic and linguistic, First Nation & Aboriginal, racialized, LGBTQ, gender, age, ability, etc.; and how your initiatives will address these groups.

8. Create shared learning opportunities for cross discipline – cross-sectoral learning at every stage. As partners with expertise in DV, mental health, and substance use work together to define and create comprehensive approaches, they need to learn about each other, their communities, the problems they hope to address, and the language they use in their sector or agency to discuss these problems. The collaboration will bring together individuals with different experiences, expertise and skills. Make the time to build a community of learning, allowing stakeholders to share knowledge, experience, and skills as you work towards consensus.

   Collaboratives are often large and it is easy for people to get lost or to feel they don't have much to offer. Creating small clusters is a way of broadening engagement and making all partners feel their time is well spent and their contributions worthwhile:
   - Conduct "cross-learning" exercises
   - Use small group activities to stimulate discussion
   - Create opportunities for partners to learn about each other
   - Make information and ideas accessible to all partners
   - Build capacity for shared decision-making
   - Use electronic tools to stay in touch between face to face meetings. This could include: videoconferencing; creating a secured, shared web location to share common documents, memos, or notes; developing an online hub for discussions; using teleconferences to meet more frequently

9. Provide opportunity and permission to broach difficult topics. Talking about difficult subjects or awkward topics is often very difficult especially when you don't want to offend the other person and when you don't want to reveal your vulnerability. But topics that are not discussed often simmer and metamorphose into bigger, out-of-control issues jeopardizing the partnership. Partners need to learn and be given permission to raise difficult topics, bring them into the open and discuss them with each other and the group no matter how awkward it may be. At times it may be helpful to bring in an external facilitator or consultant to help bring the issues into the open.

10. Don't rest on your laurels. As the partners work together and learn more about each other and see the issues presented from different lenses they can become too comfortable and base interventions

on old data. Ensure that strategies are in place to regularly acquire new relevant information, routinely monitor the effectiveness of the partnership, and provide accountability to relevant stakeholders.

Regular assessment and evaluation of the partnership's impact is vital to its ongoing relevance to its members and target population. Some areas to consider when assessing achievements and impact include:

- Are all of the necessary components in place?
- Are the issues of all demographic groups represented being addressed?
- Are all necessary supports available and accessible?
- Are we aware of emerging or changing needs and are we positioned to respond?

The idea for forming a collaborative partnership often comes from an individual or a small group seeking answers for a particular problem or from funding that is available for broad-based change, however in the long run successful and lasting partnerships rely on the ability of the group to form a cohesive body based on common vision and purpose.

Something To Think About

What skills and ways of working require cultivation in order to build cross-sectoral partnerships at your local level? What existing or emerging challenges might impact negatively on partnership building? What strategies may be useful in dealing with such challenges?

POSSIBLE PARTNERS

Use the following chart to identify potential local partners in a collaborative which seeks to improve the response and supports for women and their children experiencing DV, mental health and substance use problems. Certain potential allies/champions (either individuals/organizations) may be helpful to enlist early on as they may be able to assist in outreach to other sectors/collaborators. As you work on compiling your list of potential collaborators, consider:

- Are all sectors represented?
- Are the interests of diverse populations within the community represented (race, language, ability, sexual orientation, age, etc.)?

Partner	Sector/population Represented	Benefits of Partner Participation	Resistance/Challenges to Participation
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		

Partner	Sector/population Represented	Benefits of Partner Participation	Resistance/Challenges to Participation
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		
	❒ DV ❒ SU ❒ MH ❒ Other Population Represented		

LANGUAGE

In beginning to collaborate with those who work in other sectors, different understandings of some common words or terms may lead to problems in the partnership. It may be helpful to begin the collaboration by clarifying what each person means when they use words that may be sector specific, or potentially carry different nuances for each individual.

We have listed several words with the potential for different interpretations and ask you to think about what you mean when you say, for example, "addiction," "safety," or "harm reduction?" When you meet with potential collaborators, have them do the same. Compare your meanings and interpretations – are they the same? Do they differ? In what ways? How will you work with these differences in your collaboration?

Addiction
Assessment
Collaboration
Disclosure
Documentation/Record Keeping
Domestic Violence
Feminist
Harm reduction
Intersectionality
Mental Health/Mental Illness
Non-Disclosure
Relapse
Risk Factors
Safety/Safety Plan(ing)
Screening
Self-care
Stages of Change
Stigma
Substance Use/Dependence
Trauma-Informed Care/Services
Woman-Centred Approach

EXAMPLES OF EFFECTIVE COLLABORATIONS

Although policies and practices to work effectively with women experiencing domestic violence, mental health and/or substance use in an integrated and coordinated manner is relatively new, there are some inroads being made in Ontario and elsewhere. We will highlight those efforts here:

1. Chatham Kent Women's Centre (CKWC) (Shelter)

The CKWC is a not for profit organization providing a continuum of services, shelter, advocacy, counselling and public education to support women and children who are facing violence. It is a holistic approach offered in a non-judgmental and empowering fashion to model non-violent and respectful behaviour and relationships. The goal is to provide the Right Service, in the Right Place, at the Right Time. Because the number of clients with concurrent issues of abuse, mental health and addictions is on the rise, every effort is made to address all issues with an understanding of how the concurrent disorders and related life events interact with one another. Persons with mental illness and/or addiction are vulnerable to all forms of abuse and this may have a significant impact on their diagnosis, treatment & recovery.

CKWC has adopted a Harm Reduction Model for dealing with addictions. In using this model the goal is to prevent or reduce the harms associated with substance use. This calls for non-judgmental and non-coercive strategies and approaches and aims to provide and/or enhance skills, knowledge, resources and support for people to live safer, healthier lives. There is a recognition that abstinence is one point on a continuum of substance use and may not be desirable or achievable for some. The centre maintains a zero tolerance for use on site but acknowledges that women may have used substances while out in the community.

We also actively screen clients for mental health and addictions and will help identify and summarize priorities for action, next steps and any immediate safety issues. CKWC is also involved in a collaborative and sharing of resources between mental health, addiction and women of experience. Through experience we have found that a woman needs information and education that names the issues, provides information on services, the impact of trauma, rights, and options. She also needs a skilled and compassionate first response that identifies the concurrent issues, helps her make sense of what is happening, connects her past and present, and connects her with ongoing supports. Group sessions enable women to meet others with similar struggles, to break isolation, de-stigmatize, build support systems, and to educate. Every attempt is made to provide a safe place that de-stigmatizes addiction, abuse, mental health problems and poverty. Our counselling approach involves listening, careful pacing, thorough assessment, education, and we ask the real questions to help women see their strengths, let their feelings out and move towards healing.

We hope that this integrated approach will immediately engage women as active participants in their healing/treatment process.

For more information about CKWC go to: http://www.ckwc.ca/

2. Riverside Community Counselling Services (Western Rainy River)

Riverside Community Counselling Services has been providing Community Treatment Services for the residents of the Rainy River District, a population of approximately 18,000 since the early 1970s. Recognizing that their clients' problems stemmed from complex, co-occurring and multiple issues like abuse, addiction and mental illness they became more welcoming, comprehensive and integrated at the point of contact to promote recovery. They have adopted a workload management approach, Levels of Care, that tailors services to the individual needs of the client. An Intake Coordinator explores the client's presenting issue(s) and also screens for the possibility of addiction, problem gambling, victimization, depression, and self- harm. All counselors rotate on a weekly basis in this role, regardless of their practice specialty, in order to ensure staff remains sensitized to the likelihood that most of their clients are indeed dealing with some combination of addiction, mental health, and violence issues. At this point the results of the screening are shared with the woman for the purpose of informing awareness, motivating to work, and prioritizing the type of work to be done. Ultimately the woman's choice is respected and an internal referral is made to the most appropriate counselor for assessment, the development of a sequential treatment plan that may involve other counselor(s) or external agencies, and services are provided according to better practices. The counselors specialize in addictions, family violence, and mental health practice areas and service continues until the client achieves sufficient symptom reduction/service goal achievement that either supports discharge or transition to other service options.

Our practice has evolved out of three main factors. First we had experienced (and had plenty of anecdotal evidence from other regional resources) that women were being defined as "sick, crazy, or mentally ill" and were disproportionately ending up in institutions, unable to access shelters due to "substance use," or would present with male partners saying things like "....there's really something wrong with her ...you know." Despite being one of the few agencies in our area funded for a VAW Counsellor, we found that at one of our sites (that only had a Mental Health Counsellor) 60% of historical referrals were actually/also victims of abuse/ violence. Finally, we determined that we were spending far too much time dealing with our waiting list so we might as well eliminate it and find better business practices to serve our clients. Out of all of this came the screening tool at entry

and the assignment of all clients to an appropriate match between their readiness to move towards recovery, severity of their problems, and the frequency/duration of community treatment required (Levels of Care-Assessment/Referral, Crisis Intervention, Brief Treatment, Long-term Treatment/Rehabilitation, Follow-up).

For more information go to their website: www.riversidecommunitycounselling.on.ca

3. Jean Tweed (Substance Use Services - Toronto)

The Jean Tweed Centre was established in 1983 named after Jean Shannon Tweed – a woman who saw the need for a safe and supportive environment for women to address their substance use issues. We approach our work from a women-centered framework that validates the experiences of women and problems related to substance use and gambling within her broader social and cultural experiences including trauma, violence, poverty and other determinants of health. The women who access services frequently deal with other complex issues beyond substance use or problem gambling. Approximately 80 percent of women entering the program report a history of abuse, past and present and more than half have experienced mental health problems. Most women accessing services at Jean Tweed are mothers with more than half parenting all or some of their children.

The Centre has evolved and grown to become a leading community-based substance abuse and problem gambling agency for women in Ontario offering residential and day programming, a fully licensed child development centre, outreach services to women who have mental health and substance use problems as well as involvement in the criminal justice system. The Centre is committed to working in partnership with other related services as a means to reduce barriers, enhance capacity and provide seamless care. Working from this framework, the Centre has, more recently, expanded its reach to include mental health supports and permanent housing for women and women-led families.

For more detailed information about their programs, services, advocacy and other initiatives go to: www.jeantweed.com

4. Ontario Woman Abuse Screening Project

The Ontario Woman Abuse Screening Project, under the leadership of the London Abused Women's Centre is a collaboration involving agencies, departments and programs in different regions across Ontario, volunteers, women with lived experience and a Provincial Steering Committee.

The mandate is to collaborate across sectors to:

- implement routine screening for woman abuse, sexual assault and trauma in the mental health and addiction sectors;
- provide cross-sectoral training;
- implement woman abuse/sexual assault/ trauma-informed services in the mental health and addiction sectors; and
- provide integrated, inter-sectoral services to abused women with concurrent mental health and/or addiction issues.

The specific goals are to:

- Plan and implement woman abuse/sexual assault/trauma screening in the mental health and addictions agencies and allied services;
- Develop cross-sectoral collaboration between the woman abuse/sexual assault, mental health and addictions sectors and allied services;
- Promote woman abuse/sexual assault/trauma-informed services within the mental health and addiction sectors and allied services;
- Promote mental health and addictions-informed services in the woman abuse/sexual assault sector;
- Develop and test a web-based/webinar/ tele-learning model for supporting other regions in developing and implementing cross-sectoral collaboration, implementation of woman abuse/ sexual assault/trauma screening, and woman abuse-informed/sexual assault-informed/trauma-informed services in the mental health and addictions sectors;
- Collaborate and consult with women with lived experience and with community resources;

- Initiate integrated and/or cross-sectoral services for abused women with concurrent mental health and/or addictions issues;
- Develop a model of mentoring and supporting other agencies, sectors and regions to share learnings and ensure sustainability of the screening and initiatives;
- Support implementation of screening and trauma-informed services involving five additional regions of Ontario (beyond the four regions currently part of the Collaborative) through tele-conferences and web-based learning;
- Seek funding for the continued development of the initiative; and
- Assess and evaluate the success of the implementation of the project.

Each region has a Regional Steering Committee that guides the project in its region, develops and delivers trainings through local experts, develops the woman abuse/trauma screening tool(s) which that region will use, collaborates to develop inter-sectoral services, and coordinates with the other regions through the Provincial Steering Committee. Each region also has a Regional Lead Agency that assumes responsibility for financial and administrative functions including hiring, reporting, recordkeeping and coordination of activities within their region. The Regional Lead Agency reports quarterly to the Provincial Lead Agency.

More info can be found at
http://www.womanabusescreening.ca

5. No Wrong Door: Creating a collaborative rural response for women with abuse, mental health and addictions issues in Grey and Bruce Counties (Community Collaboration)

In 2004 the Grey Bruce Domestic Violence Coordinating Committee (GBDVCC) identified mental health and addiction as service barriers for abused women through the annual Report Card on the Community Response to Domestic Violence recommending action to address service barriers and increase sector coordination.

In 2007 the GBDVCC launched the *Rural Strategies for Women with Abuse, Mental Health and Addictions Issues* project, a participatory research project under the leadership of a multi-sector Advisory Committee that included representation from women with lived experience. The project gathered information through focus groups with women experiencing mental health, addiction and abuse issues, and service providers completing an online survey. The project organized two community workshops to develop recommendations from the data collected. Service providers from mental health, addictions and abuse sectors and service users who had participated in focus groups spent time together reviewing the data, identifying key themes, and recommending six priority areas for change and action for a more collaborative and helpful systemic response. The project final report, *No Wrong Door: Creating a Collaborative Rural Response for Women with Abuse, Mental Health and Addictions Issues* (2007) provided action items, a comprehensive literature review, and specific areas for change identified by women and providers. A central recommendation from the report was that women with lived experience steer the process of change in Grey and Bruce Counties. (The report is available at the GBVPCC website: **www.endabusenow.ca**)

In 2008 Grey Bruce became a pilot site for the provincial *Ontario Woman Abuse Screening Project* and in that same year, the Grey Bruce Mental Health, Addictions and Abuse Steering Committee took over the leadership for the implementation of the recommendations from the No Wrong Door report. The committee has active participation from women who use services, and cross-sectoral representation, and has a vision "In Grey Bruce every service door is the right door for women dealing with mental health, addictions and abuse/trauma in her life."

The funding and support from this provincial project has supported the development of a common inter-sectoral Mapping Tool, and the

development of Hope Equality Respect (HER) Grey Bruce, a support and advocacy group for women with complex issues, and opportunities for joint training and networking.

The Mapping Tool helps providers and women identify the range of issues in a woman's life (abuse, mental health and addiction) as well as the services and supports women have used. Women with lived experience had an active role in the development of the Mapping Tool, and the tool itself belongs to the woman, and is not the property of the service. It is currently being piloted throughout the two counties.

HER Grey Bruce supports the development of women's leadership to steer the process of change, and fills an important gap in the community – a safe and welcoming place organized by women and for women.

Grey Bruce is now actively working to create a "Picture of Collaboration." Over 80 providers from all sectors and women from HER Grey Bruce attended a one day networking forum to build together a picture of what an integrated delivery of service looks like, and what action is needed within organizations and sectors and in the work together across sectors.

There is excitement about the possibilities for a new way of working together, and a new way of listening to the women who use services. There is a great deal of need for change, and energy across sectors to address the status quo. The next steps for the community include moving forward with service and system integration, and building support and mechanisms for women who use services to have a legitimate and equal voice in program and service planning.

6. The Stella Project (U.K.)

The Stella Project, established in 2003, is a partnership between the Greater London Domestic Violence Project (GLDVP) and the Greater London Alcohol and Drug Alliance (GLADA). The Greater London Alcohol and Drug Alliance (GLADA), established by the Mayor of London in 2002, is a strategic network of organizations and agencies concerned with the problems caused by drugs and alcohol in London. In 2002, GLDVP and GLADA identified gaps in the current service provision for both survivors and perpetrators of domestic violence who are problematic substance users. GLDVP and GLADA therefore decided to create the Stella Project in order to find positive and creative ways to work towards more inclusive service provision.

In 2010 the Stella Project decided to incorporate sexual violence into the scope of its work. This was in recognition of the level of sexual violence experienced by women in particular who access drug and alcohol treatment services and in recognition of the research highlighting drug and alcohol use as coping mechanisms for experiences of trauma. In the same year the Project also launched the Mental Health Initiative, to promote effective partnerships between the mental health, substance use and violence against women sectors.

The Project has become the leading agency in London working for positive, sustained improvement in the way services are delivered to survivors, their children and perpetrators of domestic and sexual violence affected by problematic substance use.

Project Achievements

Through its collaborative efforts the Stella Project offers a range of services to organizations, local authorities and individual practitioners including:[13]

- Comprehensive training programmes on issues relating to substance use and violence against women
- Development of effective responses to women experiencing domestic and sexual violence, problematic substance use and psychological distress

- Improved responses to young women with experiences of domestic and/or sexual violence and substance misuse
- Supporting the development of safe and effective responses within drug and alcohol agencies
- Identifying who is doing what to whom in intimate partner violence, for drug and alcohol services
- Conducting an England-wide mapping of refuge provision for women with complex needs
- Reviewing Mental Health responses to domestic and sexual violence
- Production of a variety of resources which are available online
- Organizing networking events to practitioners from across the UK
- Supporting a group of women affected by – and campaigning for -issues relating to the way alcohol and drugs affect women in London today
- Producing a "Good Practices Guidelines" tool kit for domestic violence and alcohol

For more information, visit http://www.avaproject.org.uk/our-projects/stella-project.aspx

7. Domestic Violence & Mental Health Collaboration Project: King County, Washington State (USA)

The Domestic Violence & Mental Health Collaboration Project [14] is comprised of representatives from:

- City government
- A county-wide domestic violence coalition
- A community-based domestic violence organization
- A community mental health organization
- Two organizations that provide mental health and domestic violence services, and that serve the Latino and the Lesbian, Gay, Bisexual and Transgender communities respectively

The collaborative partners were invited to participate in this project because of their expertise in their respective fields and their leadership in addressing the mental health needs of survivors of domestic violence.

The Domestic Violence and Mental Health Collaboration Project facilitates sustainable systems change within and among the participating organizations to better meet the mental health, safety and self-determination needs of survivors of domestic violence who have been traumatized or whose existing mental health problems[2] have been exacerbated by domestic violence. The participating organizations strive to make services more accessible, holistic, and integrated, to work more collaboratively together, and effectively utilize reciprocal consultation.

Partner organizations all provide either domestic violence or mental health services, or both, and focus efforts on creating change for survivors of domestic violence who have: a disabling mental health problem as a result of trauma, or whose existing mental health problems have been exacerbated by domestic violence, and are accessing services at four of the specific partner agencies including a community-based mental health and drug/alcohol treatment service; a community mental health agency for lesbians, gay men, bisexuals, and transgendered individuals; a counselling a referral service for the Latino community; and, a multi-service domestic violence agency.

8. The Women, Co-occurring Disorders and Violence Study (WCDVS) (USA)

The WCDVS was launched in 1998 by the US Substance Abuse and Mental Health Services Administration (SAMHSA) in response to the "significant lack of appropriate services for women with alcohol, drug abuse, and mental

[2] *Definition of mental health problems inclusive of struggles with chemical dependency*

health disorders and histories of violence" (p. 1).[15] SAMHSA recognized that "women with this constellation of experiences are likely to have more severe difficulties and use services more often than women with any one of these problems alone," and that these issues are often addressed by separate service systems "with different treatment philosophies, eligibility criteria, and operating procedures, that work in isolation and are not well coordinated."[16] This study was the "first large-scale multi-site effort to develop and rigorously evaluate comprehensive, integrated services for women with histories of trauma, mental illness, and substance abuse."

The 5-year study had two phases: planning and implementation. The planning phase was a two year process that involved establishing agreements among 14 sites "representing residential and outpatient mental health and substance abuse services providers, hospitals, jails, public health agencies, universities and other community groups" that would work together to develop: a framework for integrated service interventions; a strategy for implementing the framework; and a methodology for a cross-site outcome evaluation to compare those receiving services to those receiving care or services as usual[17 18] and establishing a coordinating centre.[19] The second phase involved implementing integrated service delivery programs in nine sites (from the 14 sites in phase 1) designed specifically for women with trauma histories and concurrent issues.[20] This involved providing a core set of comprehensive services and developing strategies for integrating these services.[21] Sites were required to:

- Provide a comprehensive range of services
- Integrate the services provided[22]
- Ensure that all services were "trauma-informed," gender-specific, culturally competent, and trauma-specific[23]
- Ensure that women who were survivors of domestic violence, recovering from concurrent disorders, and consumers of these services were involved in all stages of implementation[24 25]

Sites were also required to provide a comprehensive range of complementary services, including:

- Outreach and engagement
- Screening and assessment
- Treatment activities
- Parenting skills
- Resource coordination and advocacy
- Crisis intervention
- Peer-run services[26 27]

Evaluations revealed that the WCDVS faced design and implementation challenges.[28] One was that each site provided the required elements through one of four different service models and another issues was that participants were not randomly assigned to WCDVS interventions or the control group of participants receiving care as usual. These issues made it more difficult to evaluate outcomes; however, McHugo et al. (2005) note that these difficulties were offset because the model was replicated at so many sites.[29]

In terms of cost, Domino, Morrissey, Nadlicki-Patterson, and Chung (2005) found that after start-up, the costs of the integrated services provided through the WCDVS were not significantly different from services provided through treatment as usual.[30] Cocozza et al. (2005) found that women in the WCDVS intervention conditions (i.e. exposed to comprehensive, trauma informed, consumer/survivor/recovering (CSR) women-involved approaches to care) showed greater improvement than women receiving treatment as usual.[31] Specifically, women in the WCDVS showed significantly greater improvement on PTSD scores and drug use severity as well as greater improvement on mental health status, although not statistically significant. Further, Cocozza et al. (2005) found that different sites produced different effects as sites implemented the required characteristics in different ways with different approaches.[32] Specifically, Cocozza et al. (2005) found that integrated counselling was significantly

related to the positive program outcomes noted above and concluded that the "effects of the interventions are conditioned on providing integrated counselling to women who have co-occurring disorders and violence histories" (p. 117).[33] Integrated counselling refers to a counselling approach that integrates the three key treatment foci: domestic violence, mental health disorders, and substance use disorders. Cocozza et al. (2005) suggest that integrated counselling is an effective "bottom up" strategy that integrates services at the client level, a finding that "appears consistent with emerging research that suggests the positive impact of client-level integrated services for individuals with co-occurring mental and substance abuse disorders" (p. 118).[34] Several challenges and lessons were noted by Moses et al. (2004), including:

i) A collaborative and open planning process was crucial to establish and maintain buy in from different partners with differing philosophical perspectives
ii) Effective service integration included: trauma, mental health & substance abuse services as well as many others such as criminal justice, child protective services, health care, etc)
iii) Co-facilitation was an effective strategy to improve clinical integration
iv) Co-facilitation by clinicians from different agencies (as well as CSR women) helped integrate services and make services and organizations more trauma-informed and responsive to women's needs
v) Sites that had issues with retaining women employed several strategies such as providing child care, transportation, etc to help women access these services
vi) Many sites found that groups (versus individual) helped facilitate women's continued participation and recovery
vii) Many sites recognized the need for additional care so they developed a range of follow-up services in the form of peer-run support groups
viii) Sites found that involving CSR women was very beneficial
ix) Continued cross-training is essential for all staff[35]

References

[1] Huang, B., & Perroud, T. (2003). *Our protocol for a successful interdisciplinary collaboration.* Washington, DC: American Association for the Advancement of Science. Retrieved from **http://sciencecareers.sciencemag.org/career_magazine/previous_issues/articles/2003_01_17/noDOI.11449521753182219153**

[2] Leviten-Reid, E. (2007). *Reflecting on vibrant communities (2002-2006).* Ottawa, ON: The Caledon Institute of Social Policy. Retrieved from **http://www.caledoninst.org/Publications/PDF/612ENG.pdf**

[3] Keast, R., & Mandell, M.P. (2009). *Advancing collaboration practice: Why collaborate, and why now? Fact sheet 2.* Australia: Australian Research Alliance of Children & Youth. Retrieved from **http://www.aracy.org.au/cmsdocuments/Advancing%20Collaboration%20Practice%20Fact%20Sheet%20two%20(dated)%20WEB.PDF**

[4] Keast, R., & Mandell, M.P. (2009). *Advancing collaboration practice: Why collaborate, and why now? Fact sheet 2.* Australia: Australian Research Alliance of Children & Youth. Retrieved from **http://www.aracy.org.au/cmsdocuments/Advancing%20Collaboration%20Practice%20Fact%20Sheet%20two%20(dated)%20WEB.PDF**

[5] Integrations. (undated). *Building collaborative relationships: Creating productive relationships with people and the land.* Eugene, OR: Integrations. Retrieved from **http://www.integr8.com/Collaboration%20Workshops.htm**

[6] Dichter, T. (1989). *Issues critical to a shift in responsibilities between US PVOs and Southern NGOs.* Paper to the Advisory Committee on Voluntary Foreign Aid, The DONOR.

[7] Brown, L.D., & Covey, J. (1989). Organization development in social change organizations: Some implications for practice. In W. Sikes, A. Drexler, & J. Gant (Eds.), *Emerging practice of organization development.* Alexandria, VA: University Associates.

[8] Rice, J.K., & Austria, A.M. (2007). Collaborative leadership and social advocacy among women's organizations. In J.L. Chin, B. Lott, J.K. Rice, & J. Sanchez-Hucles (Eds.), Women and leadership: Transforming visions and diverse voices. Malden, MA: Blackwell Publishing Ltd.

[9] Rice, J.K., & Austria, A.M. (2007). Collaborative leadership and social advocacy among women's organizations. In J.L. Chin, B. Lott, J.K. Rice, & J. Sanchez-Hucles (Eds.), Women and leadership: Transforming visions and diverse voices. Malden, MA: Blackwell Publishing Ltd.

[10] North Central Regional Educational Laboratory. (1996). *Putting the pieces together: Comprehensive school-linked strategies for children and families.* Washington, DC: Regional Educational Laboratory. Retrieved from **http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/ppt/chap1.htm**

[11] Jehl, J., & Kirst, M. (1992). Getting ready to provide school-linked services: What schools must do. *The Future of Children, 2*(1), 95-106. doi: 10.2307/1602465.

[12] Kagan, S.L. (1994). Leadership: Rethinking it – making it happen. *Young Children, 49*(5), 50-54.

[13] Against Violence and Abuse. (undated). *Stella project.* London: Against Violence and Abuse. Retrieved from **http://www.avaproject.org.uk/our-projects/stella-project.aspx**.

[14] Unknown author. (2010). *Collaboration charter: Domestic violence & mental health collaboration project.* King County, WA: Unknown author. Retrieved from **http://www.accessingsafety.org/uploads/File/King_County_WA_Collaboration_Charter.pdf**

[15] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/LessonsFinal.pdf**

[16] Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). The Women, Co-occurring Disorders and Violence Study and Children's Subset Study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/ProgramSummary.pdf**.

[17] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/LessonsFinal.pdf**

[18] Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). The Women, Co-occurring Disorders and Violence Study and Children's Subset Study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/ProgramSummary.pdf**

[19] Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). The Women, Co-occurring Disorders and Violence Study and Children's Subset Study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/ProgramSummary.pdf**

[20] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/LessonsFinal.pdf**

[21] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/LessonsFinal.pdf**

[22] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[23] Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). *The Women, Co-occurring Disorders and Violence study and children's subset study.* Retrieved from **http://www.prainc.com/wcdvs/pdfs/ProgramSummary.pdf**

[24] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[25] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/LessonsFinal.pdf**

[26] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[27] Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). *The Women, Co-occurring Disorders and Violence study and children's subset study.* Retrieved from **http://www.prainc.com/wcdvs/pdfs/ProgramSummary.pdf**

[28] McHugo, G.J., Kammerer, N., Jackson, E.W., Markoff, L.S., Gatz, M., Larson, M.J., & Hennigan, J. (2005). Women, Co-occurring Disorders, and Violence study: Evaluation design study and population. *Journal of Substance Abuse Treatment, 28*(2), 91–107.

[29] McHugo, G.J., Kammerer, N., Jackson, E.W., Markoff, L.S., Gatz, M., Larson, M.J., & Hennigan, J. (2005). Women, Co-occurring Disorders, and Violence study: Evaluation design study and population. *Journal of Substance Abuse Treatment, 28*(2), 91–107.

[30] Domino, M., Morrissey, J.P., Nadlicki-Patterson, T., & Chung, S. (2005). Service costs for women with co-occurring disorders and trauma. *Journal of Substance Abuse Treatment, 28*(2), 135–143.

[31] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[32] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[33] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[34] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment, 28*(1), 109–119.

[35] Moses, D.J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. Retrieved from **http://www.prainc.com/wcdvs/pdfs/LessonsFinal.pdf**

SECTION SIX:
SELF CARE AND COMPASSION FATIGUE

INTRODUCTION

Working with women who have experienced trauma or who are facing other complex problems can be both rewarding and challenging. Developing new knowledge, skills and abilities can be extremely satisfying, especially when the work helps inspire positive change. Hopefully you find the work to be meaningful and you have developed a respect for the women you work with and their resiliency. However, it is likely that from time to time you also encounter challenges.

CHALLENGES EXPERIENCED BY WORKERS

One of the most common feelings workers express when supporting women with complex problems is a sense of their own helplessness. When a woman discloses abuse, mental health and/or substance use problems, the desire to help and do something can be overwhelming. However, feeling apprehensive about saying or doing the wrong thing may inhibit a worker from doing anything at all.

Frustration can be closely related to one's feeling of helplessness; frustration that a woman doesn't acknowledge or recognize what is happening to her, or that she minimizes the dangers or associated harms.

A woman's journey toward health, healing and recovery is an ongoing process. If there is ongoing contact or a therapeutic relationship with her and she remains in the abusive relationship, denies she has any mental health problems, or is still misusing substances, a worker may find themselves blaming or judging her.

These thoughts or feelings could emerge especially if her cultural, religious, or socioeconomic background is different from the worker's own. Another complication arises if the worker has experienced similar problems and been able to overcome them, or has seen other women successfully overcome and heal from similar problems. In such situations it can be easy to become critical or judgmental, to become angry and feel a sense of injustice.

Other challenges include becoming overly preoccupied with a woman's situation and worrying about her and her children to the point where the worker's own emotional and psychological states are impacted and relationships with friends, family, other clients and colleagues are affected.

Sometimes workers enter into an area of specialization because of a personal experience which enables them to identify with the experiences of other women. While this can be a great asset and allow for a meaningful connection with one's clients, it can also be a challenge to maintain one's own integrity and boundaries. Sometimes a worker with their own past experiences may find themselves 'triggered' by a client's struggle, compromising their own wellbeing and interfering with their ability to effectively support her.

For anyone who is supporting women with complex problems, it is important to learn self-care strategies that will maximize one's resiliency and allow for a productive and healthy professional and personal life.

AN OCCUPATIONAL HAZARD?

Historically, overwhelming feelings of helplessness, frustration, anger, and exhaustion that develop in reaction to hearing client's stories of trauma, have been characterized as either "burnout" or "counter-transference."[1 2] Over the course of the last twenty

years, researchers have explored the impact of helping on helpers and a variety of other terms have emerged: "vicarious trauma;"[3] compassion fatigue;[4] and secondary traumatic stress[5] have been used to describe the effect on caregivers, helpers and health care professionals who have worked with victims of sexual violence, war veterans, trauma survivors and women experiencing abuse. Research has shown that job satisfaction, occupational commitment, quality and effectiveness of service delivery and retention, are all affected when burnout and compassion fatigue are not adequately considered.[6 7 8 9 10]

DISTINGUISHING TERMINOLOGY

"Burnout" can develop in any profession and refers to the cumulative strain of working with many different stressors. It is often a gradual wearing down over time. One may begin to doubt one's ability to keep coping constructively with the stressors and pressures. Feelings of hopelessness and difficulties dealing with work or in doing the job effectively may emerge. Factors contributing to burnout include a very high workload, difficult client populations, long hours, few resources, ambiguous success, failure to live up to one's own expectations, or a non-supportive work environment.

"Countertransference" is a therapeutic term used to describe the counsellor's parallel experience of a client's emotional state. For example, feeling helpless, hopeless, powerless when the client does. It is as if a partial and short-lived identification with the client has taken place.[11]

"Secondary Traumatic Stress" Beginning in 1995, a number of researchers (e.g. Stamm,[12] Figley,[13] Yassen[14]) began using this term to describe the signs and symptoms of stress and PTSD experienced by those who worked with trauma survivors. While not recognized as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD.

"PTSD" or Post Traumatic Stress Disorder is a response to trauma. "A normal response to abnormal events, a reaction to experiencing an event outside the range of usual experience that would be markedly distressing to almost anyone."[15]

"Vicarious Trauma" was coined by Pearlman and Saakvitne (1995) to describe those permanently transformative, inevitable changes that result from doing therapeutic work with trauma survivors.[16] The changes were not considered pathological and were seen instead as normal cognitive and emotional changes related to how the worker felt and thought about herself. The changes were cumulative and pervasive in their effects on an individual's life and tended to occur more often in highly empathic, sensitive individuals, those with a previous history of trauma and newer therapists. Vicarious trauma is the term used by Jan Richardson in the Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers prepared for Health Canada in 2001.[17]

"Compassion Fatigue" was a term coined by Figley around 1995.[18] He initially made a distinction between compassion fatigue and compassion stress. Compassion stress was a "non-clinical, non-pathological" way to characterize the stress of helping or wanting to help a trauma survivor. It was seen as a natural outcome of knowing about trauma experienced by a client, rather than a pathological process. It could have a sudden onset and perhaps with little warning and a faster recovery. On the other hand compassion fatigue was considered a more severe example of cumulative compassion stress. It is a state of exhaustion and dysfunction, biologically, physiologically and emotionally as a result of prolonged exposure to compassion stress. *"An inevitable and normal response working with individuals who have experienced trauma."*

SIGNS AND SYMPTOMS OF COMPASSION FATIGUE[19]

With compassion fatigue (which is the term that will be used to include vicarious trauma, secondary traumatic stress) one experiences the feelings of the clients including their fears and as a result may lose one's own optimism, humour and hope. Compassion fatigue is a descriptive term not a disease or diagnosis.

When workers become overwhelmed by traumatic material they may begin to avoid or deny their client's experiences or push clients too quickly in an effort to maintain control of their own responses.[20] There are a number of indicators that have been identified to help one make a distinction between burnout and compassion fatigue. Below is a list of signs compiled by Figley to help identify the signs of compassion fatigue.

Impact on Personal Functioning[21]

Cognitive	Emotional	Behavioural
• Diminished concentration • Confusion • Loss of meaning • Decreased self-esteem • Preoccupation with trauma • Trauma imagery • Apathy • Rigidity • Disorientation • Whirling thoughts • Thoughts of self-harm or harm toward others • Self-doubt • Perfectionism • Minimization	• Powerlessness • Anxiety • Guilt • Anger/rage • Survivor guilt • Shutdown • Numbness • Fear • Helplessness • Sadness • Depression • Hypersensitivity • Emotional roller coaster • Overwhelmed • Depleted	• Clingy • Impatient • Irritable • Withdrawn • Moody • Regression • Sleep disturbances • Appetite changes • Nightmares • Hyper vigilance • Elevated startle response • Use of negative coping (smoking, alcohol or other substance use) • Accident proneness • Losing things • Self harm behaviours

Spiritual	Interpersonal	Physical
• Questioning the meaning of life • Loss of purpose • Lack of self satisfaction • Pervasive hopelessness • Listlessness and dissatisfaction resulting from lack of interest and spirituality • Anger at God • Questioning of prior religious beliefs	• Withdrawn • Decreased interest in intimacy or sex • Mistrust • Isolation from friends • Impact on parenting (protectiveness, concern about aggression) • Projection of anger or blame • Intolerance • Loneliness	• Shock • Sweating • Rapid heartbeat • Breathing difficulties • Aches and pains • Dizziness • Impaired immune system • Lump in throat • Restlessness

Impact on Professional Functioning

Job Performance	Morale	Interpersonal	Behavioural
• Decrease in quality • Decrease in quantity • Low motivation • Avoidance of job tasks • Increase in mistakes • Setting perfectionist standards • Obsession about details	• Decrease in confidence • Loss of interest • Dissatisfaction • Negative attitude • Apathy • Demoralization • Lack of appreciation • Detachment • Feelings of incompleteness	• Withdrawal from colleagues • Impatience • Decrease in quality of relationship • Poor communication • Focus on own needs • Staff conflicts	• Absenteeism • Exhaustion • Faulty judgment • Irritability • Tardiness • Irresponsibility • Overwork • Frequent job changes

A NEW MODEL TO UNDERSTAND PROFESSIONAL QUALITY OF LIFE

Over time the study of work life fatigue and satisfaction has evolved, changed and become more refined. The current thinking now includes the concept of compassion satisfaction.

"Compassion Satisfaction" describes a process which involves the development over time of a much stronger sense of strength, self-knowledge, confidence, sense of meaning, spiritual connection and respect for human resiliency. Compassion satisfaction takes into account the satisfaction that workers can and do experience in their work. While vicarious trauma, secondary traumatic stress and compassion fatigue focus on the negative effects of working with trauma survivors, compassion satisfaction recognizes that the majority of individuals who work with trauma survivors find the work extremely satisfying.

Since the original Compassion Fatigue test was developed by Figley in 1995, Stamm and Figley have developed a newer version of this assessment tool; a newer version of this assessment tool now called the Professional Quality of Life (ProQOL). In this newer version both compassion fatigue and compassion satisfaction are recognized and the focus is on how one feels about one's work as a helping professional.[22] Figure 1 (see below) is an illustration of this model.

Figure 1: Diagram of Professional Quality of Life[23]

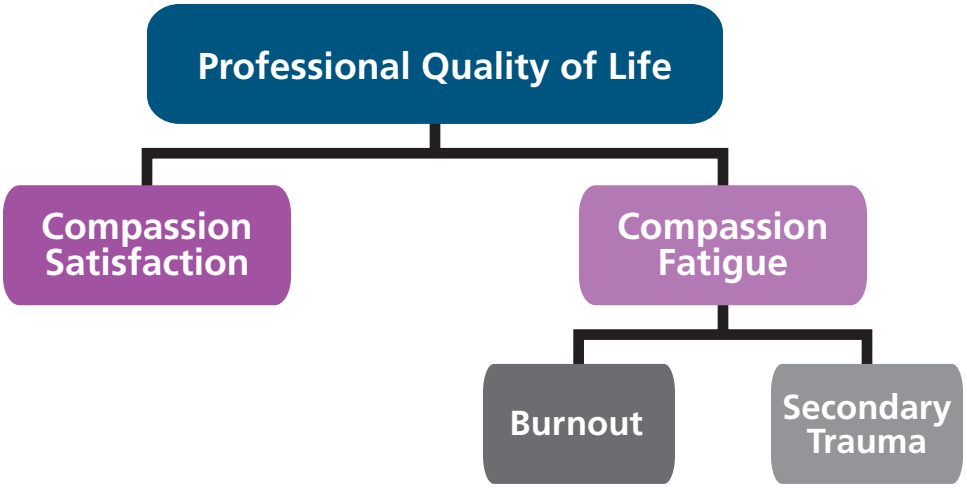
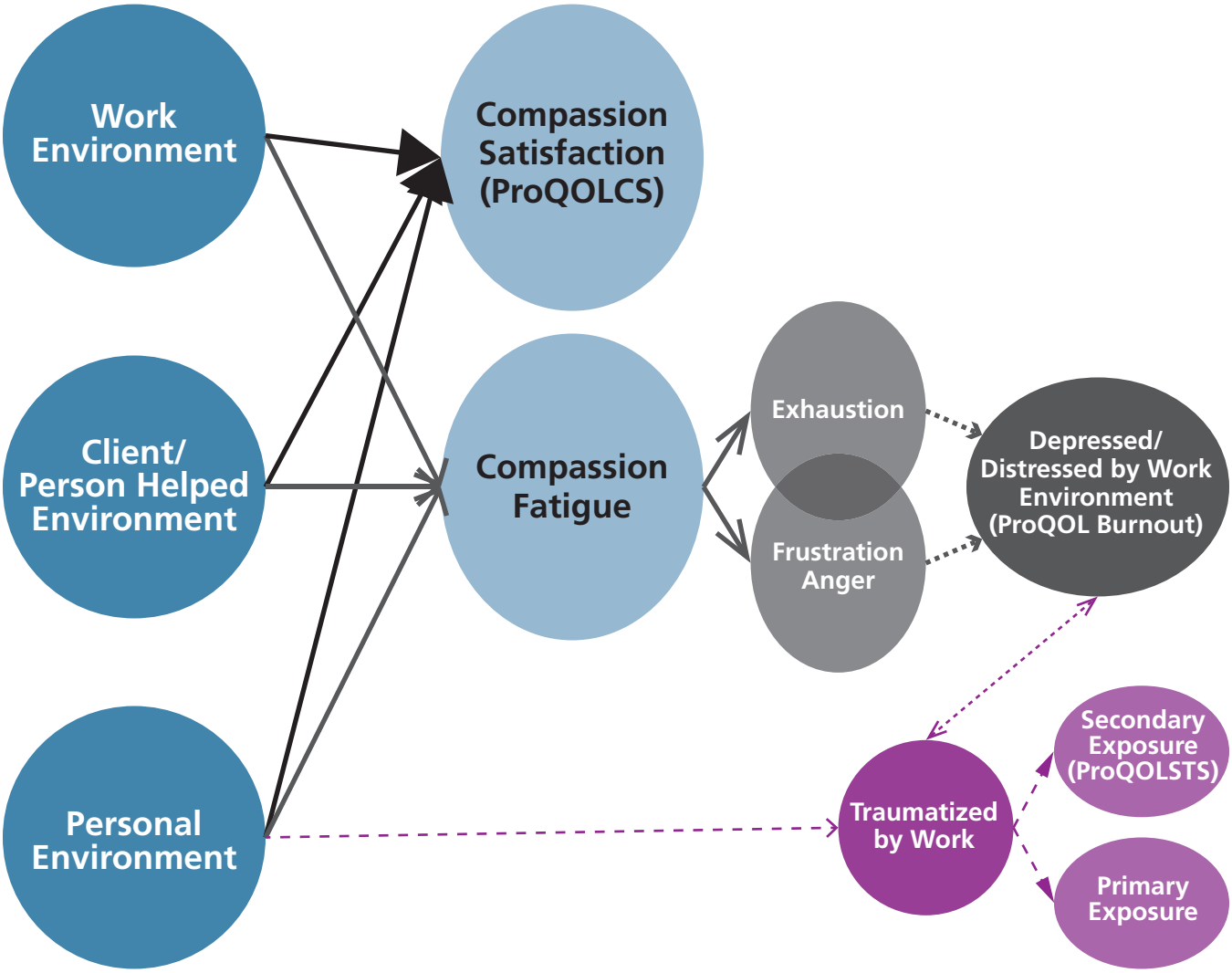


Figure 2 (see page 141) illustrates that ProQOL takes into consideration the influence of the work environment, the client's environment and the helper's environment. Each of these environments, as well as their interaction with each other, influences whether a worker experiences compassion satisfaction or fatigue.

Work Environment takes into consideration:

- Workload distribution to match skill; complexity and difficulty of client
- Organizational Culture: the impact that working with trauma survivors has on the staff and organization; encouraging self-care for workers like taking breaks, vacations
- An environment that is safe, comfortable and conducive (offering privacy) for the work to be undertaken, supportive whereby there are opportunities for staff to debrief informally and formally, assisting each other with paperwork, backup

Figure 2: Full Compassion Satisfaction–Compassion Fatigue Model



- Professional development opportunities
- Supervision

Client/Person Helped and Personal Environment include individual characteristics and qualities like coping skills, communication styles, self-esteem, personal relationships, attitudes, values and beliefs, education, income, religion/spirituality, sexual orientation, gender, age, etc.

With an overview of the concept, signs and symptoms of compassion fatigue and compassion satisfaction, you may want to assess your own current state of well-being. This Self-Care in Life Inventory by Figley can be found on page 147 and you can access the ProQOL at **www.proqol.org/uploads/ProQOL_5_English.pdf**

When looking at your results, remember:

- Compassion fatigue is not a constant and actually exists on a continuum. At times you may be impacted more than others.

- Having a high score may mean that there are a number of issues related to your stress that warrant your attention.

- Sometimes the scores simply confirm what you already know or you may be surprised. Perhaps the surprise is that you were not aware that certain symptoms are related to the stress of your work. If that is the case, then the test was worth taking and the "surprises" can serve as alerts to what needs your attention.

- If you feel uncomfortable or anxious about the results, it may be because you are now forced to look at what is causing you discomfort and distress. If the results upset you, it may be because it is the first time in a long time that you've looked at how your work is impacting you and your life. Taking a close look at ourselves is not easy. Working with women experiencing domestic violence, mental health and/or substance use problems is very challenging. Perhaps the results will become a prompt to engage in more self-care.

- The score shouldn't matter. **What matters are the items on the test which concern you.** When you are done go back and examine all the compassion fatigue items which create stress for you. Use this information as a baseline, not to judge yourself, but just as information. **Use the information to inspire you to change.**

STRATEGIES FOR SELF-CARE

There are a number of different models and sources of information on self-care including the one by Jan Richardson prepared for Health Canada.[24] Figley (1999, 2002) has also drafted Standards of Care for the Practitioner[25] [26] which have been adopted by Green Cross Academy of Traumatology.[27]

Pearlman and Saakvitne identified four domains that are important in minimizing the negative impact of providing care:[28]

1. Professional strategies: balancing workload, accessible supervision and professional development opportunities
2. Organizational strategies: sufficient time off and breaks from hearing stories of trauma and human suffering; safe physical space
3. Personal strategies: respecting one's own limits, maintaining time for self-care activities, commitment to life long learning
4. General coping strategies: self-nurturing behaviours and seeking with connections with people, nature and things of importance

We would suggest an important 5th strategy

5. Connect with like-minded colleagues, organize, collaborate and advocate for social change. As noted in the section on collaboration, working with others can enhance and enrich one's sense of self and increase work satisfaction while working for social justice can bring a sense of community and hope

Of course, self-care is only one part of the equation in responding effectively to the ongoing reality of listening to women's stories of abuse, pain, anger and humiliation. In addition to such individual solutions, as Pearlman & Saakvitne and others have noted organizational approaches are also required to ensure that workers experience healthy work lives.

An organization's communication pattern can be the most important factor in creating a healthy or unhealthy work environment. Communication patterns and structures that contribute to the development of 'insiders and outsiders' within the organization as well as other inequities can create a toxic work environment and affect the wellbeing of all staff and volunteers. In such cases, "the rewards of work by women for women may be lost, pride in the work may be jeopardized, and strength and resourcefulness may be temporarily misplaced."[29]

STRATEGIES FOR PREVENTION

Within an organization there may be at any one time, workers who feel well and fulfilled in their work, others who feel some symptoms of compassion fatigue and others who feel that there is no way to change the situation and so remain disconnected with work, clients, colleagues and others who may see no other answer but to leave the profession. It is important to identify what creates satisfaction in the work and support those elements and equally important to identify and address those areas that contribute to compassion fatigue at an organizational and individual level.

At an organizational level there should be policies and procedures in place that recognize the valuable contribution staff make in the work they do as well as the impact that this type of work can have on the individual, team and organizational health and well-being. Policies and practices that would support this include:

- Encouragement to take ***vacations*** and time off
- Implement extended ***health care benefits***
- Establish a ***well-being committee*** or add it to the Health and Safety Committee to ensure that self-care for staff is addressed
- Provide ***professional development*** opportunities on compassion fatigue to increase awareness and understanding, and ***team building*** days to promote connections, communication, camaraderie
- Provide *clinical supervision on a regular basis.*
- Encourage staff to access the ***Employee Assistance Program***, if applicable
- When hiring ***screen candidates for their resilience and awareness*** the rewards and risks of working in this area
- Create ***peer support groups*** to discuss client and staff concerns about the work
- Develop a ***Critical Incident Debriefing*** process to ensure that staff, volunteers and clients have an opportunity to receive compassionate support and participate using the critical incident debriefing model
- ***Create self-care days*** at work bringing in health and wellness specialists like massage therapists, yoga, nutritionists, etc.

Remember that front line staff are not the only ones who are susceptible to compassion satisfaction or compassion fatigue. All staff and volunteers in an organization have the potential to be affected and therefore efforts should be inclusive of everyone.

On an individual level, tips for workers include:

- ***Assess your own level of compassion satisfaction/compassion fatigue*** by completing the tool. It is important that you do it more than once over time. Compassion fatigue exists on a continuum, which means that you may be more immune at certain times and in certain conditions than on other occasions.
- ***Develop early warning system for yourself*** – compassion fatigue is a normal consequence in the helping professions. The best way is to develop excellent self-care strategies and an early warning system to let you know you are moving into the caution zone of compassion fatigue.
- ***Take an inventory of where things are at in your life.*** Make a list of all the things that consume your time and energy. Try and make it as detailed as possible, for example regarding work, list the main stressors like number of clients, amount of paperwork, etc. Once completed try and identify what may be contributing to your situation and what would you like to change most.

- ***Create a self-care list.*** Either on your own or with friends make a list of your favourite self-care strategies. You could even create a contest at work to see who can identify the best self-care strategy for the week. Once you have created the list, commit to doing 3 things within a specific time period.

- ***Find time for yourself, daily***. Try to rebalance your workload. How can you take minibreaks everyday? Can you configure your schedule so that you don't see your most challenging clients in the same day? Try and find 5 minutes to stop and sit quietly and relax.

- ***Delegate.*** Don't be afraid to ask for help. Everyone wants to contribute. By asking for help you are contributing to others.

- ***Learn to say no (or yes) more often.*** Being in a helping profession means you like to help. Does that mean you always say yes or can you say no. Ask yourself which you need to do more often.

- ***Learn about Compassion Fatigue, Vicarious Trauma.*** Education and information are extremely powerful tools. The more you know the more control you have over how to recognize and address the problem.

- ***Join a supervision or peer support group.*** Although the work you do may be on your own, you are not alone. This can provide you and your colleagues with an opportunity to debrief and support each other.

- ***Participate in Professional Development Opportunities.*** Participating in professional training and development opportunities is an excellent way to stay renewed and excited about your work.

- ***Focus on successes and allow for setbacks.*** Life is a roller coaster ride. There are ups and downs, times where things speed up and you need to change course quickly. Acknowledge and celebrate the successes with yourself and with your clients and also allow for setbacks. Remember setbacks may be opportunities for learning.

- ***Exercise.*** Lots of research indicates that physical activity is good for your health. You probably tell your clients of the importance and benefits of exercise. Do you practice what you preach? Is it possible to bring in a yoga instructor or Tai Chi instructor to your organization on a regular basis?

- ***Actions for Health and Stress Reduction.*** Get enough rest and eat healthy foods to replenish and fuel your body. Watch for weight gain or loss and pay attention to your own use of substances as aids to relaxation or sleep. Remember your body is your tool to do the work you do. Think about a car that doesn't have gas or oil changes, or tune ups – what happens it doesn't run or at least not properly. You deserve the same attention.

- ***Build a sense of satisfaction.*** Develop a mission statement for your life and take stock of where you are now, where did you start, and are you still living your mission.

ASSESSING SELF-CARE

To help reflect on current strategies and provide suggestions for other strategies that may be incorporated into your life, there is the "Self-Care Inventories" (see pages 145-146). The inventories examine two different dimensions – a personal focus, Self-Care Life Inventory, and one related to work, Self-Care @ Work Inventory. Similar to the ProQOL Tool (found at **www.proqol.org/uploads/ProQOL_5_English.pdf**), the results should be regarded as useful information and clues into areas where you may want to make some changes.

Self-Care in Life Inventory[30]

Basic Self-Care Needs	Yes	No	Goal
1. Do I usually get enough sleep?			
2. Do I usually eat something fresh and unprocessed every day?			
3. Do I allow time in my week to touch nature, no matter how briefly?			
4. Do I get enough sunlight, especially in wintertime?			
5. Do I see a medical practitioner at least once a year?			
6. Do I see a dentist every six months?			
7. Do I get regular sex thrills?			
8. Do I get enough fun exercise?			
9. Am I hugged and touched amply?			
10. Do I make time for friendship?			
11. Do I nurture my friendships?			
12. Do I have friends I can call when I am down, friends who really listen?			
13. Can I honestly ask for help when I need it?			
14. Do I regularly release negative emotions in a healthy manner?			
15. Do I forgive myself when I make a mistake?			
16. Do I do things that give me a sense of fulfillment, joy and purpose?			
17. Is there abundant beauty in my life?			
18. Do I allow myself to see beauty and to bring beauty into home and office?			
19. Do I make time for solitude?			
20. Am I getting daily or weekly spiritual nourishment?			
21. Can I remember the last time I laughed until I cried?			
22. Do I accept myself for who I am?			
Total of Yes and No responses[1]			

[1] *Yes number lower than 10 indicates violation of standards of self care and highly vulnerable to health and mental health problems.*

Self-Care at Work Inventory[31]

Self-Care @ Work	Yes	No	Goal
1. Do I take a lunch break every day and do something unrelated to work?			
2. Do I work reasonable hours?			
3. Do I schedule "breathing room every day so I can step back, and re-evaluate my priorities?			
4. Is my office free of clutter?			
5. Do I have adequate lighting and clean air?			
6. Do I delegate work to free my time and empower others?			
7. Do my family/friends honour my work time? If no, have I asked them?			
8. Do I have blocks of uninterrupted time without distractions and interruptions?			
9. Do I have a DO NOT DISTURB sign?			
10. Have I scheduled specific times for returning phone calls and checking emails?			
11. Have I stopped taking on more than I can handle?			
12. Do I drink enough water when I am at work?			
13. Do I have comfortable shoes/slippers at my office?			
14. Do I schedule time off from work (sick leave and/or vacation time) to take care of myself?			
15. Do I have someone to talk with about my professional life?			
16. Do I have creature comforts that make my office pleasant? (music and other sounds, aroma, artwork)			
17. Do I say yes to commitments that I later regret?			
Total of Yes and No responses[2]			

[2] *More than 8 no answers is a violation of the Standards of Self Care.*

FINAL THOUGHTS

Remember that working with women experiencing violence, mental health and substance use problems will have an impact. How that impact manifests itself will be different for everyone. Take time to increase your awareness of what the impact may look and feel like. Acknowledge that you may behave and feel differently as a result. Find a balance between your personal and professional life. Recognize your limits personally and professionally.

You may have knowledge about DV, mental health and substance use, but you are not an expert in the lives of the women you work with. You can assist them by focusing on their strengths, listening to their needs and recognizing the complexity of their lives. Do the same for yourself.

Have realistic expectations of yourself. You are human and can only do so much. Remember self-care is not a selfish act. It is imperative that you take control of your health and well-being. Managing your stress, being aware of the impact of working with women experiencing complex problems and taking time to reflect on your life will only increase your effectiveness as a worker, colleague, friend, family member and loved one.

Something To Think About

What strategies do you currently use to take care of yourself? What self care strategies are you able to integrate into your work life? What strategies could the organization implement to support a healthy work environment?

References

[1] Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* London: Brunner-Routledge.

[2] Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton & Company.

[3] Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton & Company.

[4] Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* London: Brunner-Routledge.

[5] Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators.* Lutherville, MD: Sidran Press.

[6] Bride, B.E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and occupational commitment in substance abuse counselors. *Traumatology, 17*(1), 22-28. doi: 10.1177/1534765610395617.

[7] Slattery, S.M., & Goodman, L.A. (2009). Secondary traumatic stress among domestic violence advocates: Workplace risk and protective factors. *Violence Against Women, 15*(11), 1358-1379. doi: 10.1177/1077801209347469.

[8] Bride, B.E., Hatcher, S.S., & Humble, M.N. (2009). Trauma training, trauma practices, and secondary traumatic stress among substance abuse counselors. *Traumatology, 15*(2), 96-105. doi: 10.1177/1534765609336362.

[9] Trippany, R.L., White Kress, V.E., & Wilcoxon, S.A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counselling & Development, 82,* 31-37.

[10] Zimering, R., Munroe, J., & Gulliver, S.B. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times, 20*(4), 43-47.

[11] Reich, A. (1951). On Counter-Transference. *International Journal of Psycho-Analysis, 32,* 25-31

[12] Stamm, B.H. (Ed.) (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville, MD: Sidran Press.

[13] Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* London: Brunner-Routledge.

[14] Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* London: Brunner-Routledge.

[15] American Psychiatric Association. (1988). Diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV). Arlington, VA: American Psychiatric Association.

[16] Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton & Company.

[17] Richardson, J.I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers.* Ottawa, ON: Public Health Agency of Canada.

[18] Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* London: Brunner-Routledge.

[19] Figley, C.R. (2004). *Compassion fatigue educator course workbook.* Retrieved from **http://www.gbgm-umc.org/shdis/CFEWorkbook_V2.pdf**

[20] Baranowsky, A.B. (2002). The silencing response in clinical practice: On the road to dialogue. In C.R. Figley (Ed.), *Treating compassion fatigue.* New York: Routledge.

[21] Figley, C.R. (2004). *Compassion fatigue educator course workbook.* Retrieved from **http://www.gbgm-umc.org/shdis/CFEWorkbook_V2.pdf**

[22] Stamm, B.H. (2009). *Full CS-CF model.* Pocatello, ID: ProQOL.org. Retrieved from **http://www.proqol.org/Full_CS-CF_Model.html**

[23] Stamm, B.H. (2009). *Full CS-CF model.* Pocatello, ID: ProQOL.org. Retrieved from **http://www.proqol.org/Full_CS-CF_Model.html**

[24] Richardson, J.I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers.* Ottawa, ON: Public Health Agency of Canada.

[25] Figley, C.R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators.* Lutherville, MD: Sidran Press.

[26] Figley, C.R. (Ed.) (2002). *Treating compassion fatigue.* New York, NY: Routledge.

[27] Green Cross Academy of Traumatology. (2004). *Standards of self-care.* Becker, MN: Green Cross Academy of Traumatology. Retrieved from **http://www.greencross.org/index.php?option=com_content&view=article&id=184&Itemid=124**

[28] Pearlman, L.A., & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (Ed.), *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

[29] Richardson, J.I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers.* Ottawa, ON: Public Health Agency of Canada.

[30] Figley, C.R. (2004). *Compassion fatigue educator course workbook.* Retrieved from **http://www.gbgm-umc.org/shdis/CFEWorkbook_V2.pdf**

[31] Figley, C.R. (2004). *Compassion fatigue educator course workbook.* Retrieved from **http://www.gbgm-umc.org/shdis/CFEWorkbook_V2.pdf**

PERSONAL NOTES

When Domestic Violence, Mental Health and Substance Use Problems Co-Occur