Freedom from Violence

Tools for Working with Trauma, Mental Health and Substance Use

FEEDBACK FORM

After reviewing the resource tool kit, please take a moment to complete the following questions and fax your responses (no cover page necessary) to 604-633-2507. Your feedback is needed in order to guide us regarding possible further editions of the kit and to relay to our funders.

1. Your awareness of the intersection of trauma, mental health and substance use increased after reviewing this kit. (circle the appropriate number)

①	②	③	④	⑤
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

2. Information in the kit have increased your effectiveness when working with multiple issue clients.

①	②	③	④	⑤
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

3. Your knowledge of safety planning with women has increased after reviewing the kit.

①	②	③	④	⑤
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

4. Information in the kit is easily accessible.

①	②	③	④	⑤
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Other feedback: _____

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Thank you for your time   Return by fax to 604-633-2507 (no cover page necessary)

Freedom From Violence

Tools For Working With Trauma, Mental Health And Substance Use

Resource Tool Kit

November 2007

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1.1 Use of Language and Diverse Voices in the Tool Kit

Aim Of The Tool Kit

The aim of this tool kit is to actively engage readers in applying a feminist analysis to women's experiences of mental health, substance use and past and current experiences of violence. The tool kit contains a wide variety of voices that speak to these issues by drawing on a range of sources: the experience of providing services to women, theory, research, feminist activism and scholarship and, naturally, by the writers' own experiences of substance use, mental health problems and violence.

In producing this kit we have allowed these different voices to emerge, and we see them as a key strength in helping to provide a rich and diverse document. In gathering these contributions together, we have collected service providers' narratives, honouring oral tradition through the practice of interviewing women practitioners and using their analysis to inform this work. We have also asked women who have experience of violence and of using anti-violence services to write about what helped them and to ask their service provider supporters to provide a commentary on their experience of working with them. The stories of survivors are placed throughout the tool kit, and we hope that they will illustrate both the barriers that women with multiple issues face in reaching safety and accessing effective services as well as the importance of working from an integrated model of addressing violence, mental health and substance use. Contributors and reviewers of the kit have come from various professional backgrounds, including: research, advocacy, community organizing, Community-Based Victim Assistance, Stopping the Violence Counselling, Stopping The Violence Outreach and other service provision. It is our hope that you find the diverse perspectives and contexts contained in this kit helpful in assisting you to expand your knowledge and in providing new tools for your support work with women.

Scope Of The Tool Kit

We are focusing on women who have survived violence and who are dealing with mental health and substance use issues because that is an area in which our membership[1] has asked us to provide resources. The scope of the kit does not allow us space to address the particular safety and support needs of all women with disabilities, including women with developmental disabilities. There is a section on working with women with FASD, which relates to women who have a brain-based disability. This is the only section that has a wider disability focus. There is a significant need for more information and tools on supporting women with disabilities who experience violence and this warrants its own manual, which we hope could be produced in the future.

...providing new tools for your support work with women.

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[1] The BCASVACP has been receiving requests for the development of a resource like this since 1999. In the spring of 2007, the BCASVACP surveyed STV counsellors, STV Outreach workers and Community-Based Victim Assistance workers about what material they wanted this tool kit to cover. The contents reflect the input we received from them and from our advisory committee.

We have provided some helpful resources on women with disabilities and violence in relationships in our resources section at the end of this kit. Another area that we have not been able to address adequately is violence against transgendered people. There are high rates of violence directed towards people who identify as trans (the impact of violence can be different and access to services more limited); however, these issues are beyond the scope of this kit to address[2].

Language Used In The Tool Kit

Language is a complex area in the fields of mental health, substance use and violence against women. It can be a site of struggle, particularly when trying to adequately describe personal experiences within wider contexts of power and resource inequality, such as gender inequality. Language shifts and evolves with changes in our values and ways of understanding these issues.

Feminists have argued that much of the language traditionally used in the mental health and substance use fields can be viewed as pathologizing women's responses to violence, trauma, poverty and inequality.

When we decided to write this document, we had to make some choices about our use of language. We wanted to find language that captured the considerable differences existing across personal experiences as well as the commonalities.

Anti-Violence Language

We have chosen to use the terms "violence," "trauma" and "abuse" interchangeably in an attempt to address the breadth of violating experiences that women are subjected to. Violence includes physical, sexual and emotional abuse and financial exploitation in relationships with men and in same-sex/gender relationships; sexual assault and criminal harassment. Abuse includes historical experiences of child physical and sexual abuse and neglect. Trauma stems from all of these experiences, and includes the impact of colonialism, ableism, racism, heterosexism and other systemic oppressions that can hurt and violate women as much as an act of physical or sexual violence.

Mental Health Language

The term "mental illness" is still very common in Canadian research and literature that describes mental and emotional experiences that are unusual or problematic. This term is situated very clearly in the medical approach to health. Many argue, however, that some conditions, particularly very common ones, could be seen as normal life experiences rather than illness. For example, severe low mood, typically described as depression, is a very common experience for people to have at some point in their lives, especially for women.

Also, many who are labelled as having mental illness or mental health problems do not describe their experiences in these ways, and instead create their own meaning and ways of describing their experiences to others and for themselves. One example of this is the movement of people who hear voices who have begun to radically challenge the dominant view of psychiatry that hearing voices is an unusual and negative experience that indicates a serious mental illness requiring medical intervention and medication. They argue that hearing voices is actually much more common than generally realized, particularly amongst people who have had intense experiences of some kind, including experiences of loss, violence or trauma.

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2   Please see the Vancouver Coastal Health website for an excellent range of resources and links on transgender health: *http://www.vch.ca/transhealth/ resources/library/index.html*. Please also see "Safety assessment and planning for people in abusive trans relationships" in Aid to Safety Assessment and Planning (ASAP) Manual for Women Who Experience Violence in Their Relationships, by the BC Institute Against Family Violence (2006). There is also a good leaflet containing information and resources produced by the BCASVACP accessible at *www.endingviolence.org*.

The contributors to this kit do not subscribe to a medical model of understanding mental distress, so this tool kit will not use the term mental illness. Instead we use the terms "mental health problem" and "mental health issue," though of course this is still not a perfect solution.

The kit will use the term "consumer" or "survivor" when talking about women who are past or current users of the mental health systems. Consumer is a term that is situated within the mental health system and is currently adopted by many people who access that system, alongside the term survivor. The term survivor in this context means that the person is a survivor of their life experiences, their mental health difficulties or the mental health system itself.

Substance Use Language

In writing this tool kit we recognise that there is a continuum of substance use and the line between "use" and "misuse" varies considerably. Because of this, and because of our aim to avoid making judgments about a women's substance use, we have chosen to use the terms "substance use" or "problematic substance use," rather than substance abuse. "Substances" include licit drugs: alcohol, tobacco, prescription drugs and solvents, and illicit drugs: marijuana, heroin, cocaine etc. Services for those with substance use problems are referred to as "substance use or addiction services."

1.2 Survivor's and Service Provider's Stories

A Survivor's Story[1]

A question prompted me to reach out and make that first phone call to a women's service. The question was about my rights regarding stalking by a past abuser that has lasted for the past 20+ years. I know that's a long time and some may ask why and my answer is…. Because I didn't know I could do anything about the situation without compromising my SAFETY and my standing in the community. It's not a thing that many people have the stomach for, and 20 years ago I was filled with fear, shame, hopelessness and last, but certainly not least, there were not a lot of resources available for me to access and those that did exist could not help me establish a plan that was going to help me stay safe through the process.

When I heard a friendly voice answer the phone at the local women's service, I felt my mouth go dry, my thoughts were scattered and my words sounded like gibberish, at least to me. When the voice on the other end of the line answered my question with an unequivocal YES, you do have a very good reason to call the police and make a complaint, I felt a balloon of hope rise in my chest and the first tears of healing rolled down my cheeks.

I am going to guess that it was the balloon of hope and the tears of relief that gave me the strength to reach out with the other hand and believe me when I say, I was not disappointed! I WAS VALIDATED! I can only say that for the first time in 20 years, I could stand up and say NOT ANYMORE…I AM TAKING BACK MY POWER.

When I called the RCMP and began the process of stopping up the leaking hole in my life, a new process began…healing. With the momentum I had gathered after making that first phone call, I called again, knowing that I was going to need some help with the logistics of court and the legal system and I was also going to need emotional support like never before! There they were all in one building.[2] Even today while writing this I get teary because I had, for lack of a better description, found what was sitting at the end of a rainbow…a nice shiny life toolbox to hold the new tools that were waiting to be used by me.

We began to work on one of the larger cornerstones of healing and that was MY SAFETY. They were pivotal in helping me create a SAFETY PLAN by providing me with information and options. Over the past 20+ years I did not feel safe and had spent too much time and energy being defensive rather than offensive…that never did work out very well for me. The SAFETY PLAN enabled me to redirect my energy towards other areas that would set into motion positive actions that would further maintain my SAFETY. Metamorphosis from victim/survivor to THRIVOR is evolving as I type.

The most difficult and challenging part of this new path was opening that first door. Yep, that was the door that, to my dismay, led to a hallway of other closed doors to rooms that needed to be opened and aired out or overhauled. Some rooms needed to be re-wired, while others needed some paint and then there were some that needed a complete makeover. However daunting the task(s) before me would be…I was now NOT ALONE. I had the beginnings of my HEALING FOUNDATION.

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1 All survivors who shared their stories were given an honorarium to acknowledge their contribution.
2 The service that this woman used has a transition house, Community-Based Victim Assistance Program and STV Counselling and Outreach program in one building.

My days are more tolerable and sometimes I even find myself feeling happy. I try not to let the days when a new "trigger" arises take me over like so many times before. I work with the tools given to me by my counsellor.

A Service Provider's Story

The woman I am working with accessed my services because she no longer felt she could cope with the stress of being harassed by an ex-partner for numerous years. She was finding it difficult to attend work and was functioning with an intense level of hypervigilance and fear on a day-to-day basis. She expressed a desire to finally go to the RCMP with her experience of being harassed and I referred her to my CBVAP colleague to assist with that piece. The woman had also been accessing the mental health system over this period of time, yet she did not feel her work with this system was effective. As our work with her progressed, she expressed relief with our abilities in the anti-violence sector to tie together her experience of abuse, mental health assessment and current behaviour in response to ongoing trauma.

In responding to the complexities of this women's experience, I felt it necessary to create a framework of safety. There was a strong need for physical safety measures to be implemented, which the CBVAP worker was able to develop with the woman and the RCMP. In this particular case, the RCMP responded quickly and because of their positive working relationship with the CBVAP worker, played a role in validating the woman's experience. I feel the collaboration between the CBVAP worker, myself and the RCMP was a key component in her capacity to feel a sense of security. The other area of safety that was immediately worked with was her emotional safety. I worked with her to normalize the trauma-related responses she had been experiencing and to create some control over her own environment. We worked with both internal responses (anxiety, containment of emotions, stress-reduction tools) and external environment (the woman chose to quit a workplace that was causing her a great deal of stress, thus giving her time to focus on caring for herself).

Throughout my work with the woman, we redeveloped a relationship with the mental health professionals, as she, like many of the women I see, was on medication, which required ongoing consultation with a psychiatrist. My role in assisting the woman to navigate the mental health system was via encouraging her to advocate for herself with her psychiatrist regarding medication changes and her request for advocacy in order to obtain long-term disability. The woman also used her doctor as an advocate with the mental health system to ensure the treatment she was receiving was not causing further difficulties in relation to how she was feeling (e.g. three-month delays between psychiatrist appointments, ever-changing prescriptions of mood-altering medication).

At first I felt disheartened about the relationship the woman had with the mental health system over such a long period of time. How could a person with such obvious mental health difficulties, who had articulated the impact of her ongoing traumatic experience to the mental health professionals, be treated with such "bare bones" basic care? I still feel the mental health system fails to capture the link between trauma and mental health. However, through building connections with those working in the mental health system and liaising as a team to address women's issues, I feel we are beginning to capture the intersection of trauma and mental health and are better equipped to provide tangible supports to those seeking services.

The most significant theme from this story that has affected my work with women is how much I learned from the woman and her amazing resilience and courage to undergo transformation under great vulnerability.

This woman expressed her satisfaction that the CBVAP worker and I had consistently sent the message that she was in charge of her healing process. This experience has affirmed for me that as service providers, it is in our capacity to sit with women and humble ourselves in our knowledge of the human experience that we are most effective in supporting their journey of transformation.

1.3 Trauma, Mental Health and Substance Use Within an Anti-Oppression Perspective

By Angela MacDougall, Tessa Parkes, Sarah Leavitt and Susan Armstrong

In this section we outline some key elements of a respectful, effective, anti-oppression approach to working with women who have experienced violence and who use substances or have mental health issues.

These elements include:
- Coming from a foundation of honest self-reflection
- Asking value-neutral questions and listening to the answers
- Examining and resisting societal beliefs about mental health and substance use; understanding oppressions such as racism, sexism, ableism, poverty, homophobia, transphobia, colonization, etc and how they relate to beliefs about mental health and substance use
- Maintaining an attitude of engaged neutrality when providing services
- Focusing on behaviours and context as opposed to labels and diagnoses

The approach that we describe here is simple and complicated at the same time, like much of the work that we do with women who have experienced violence. As you read through this section, you might find yourself thinking that it sounds very simple, and it really is: at its heart, this approach is simply about working with women in a respectful, open manner. However, at the same time, it is very complicated: it requires unlearning many beliefs that we have been taught, becoming aware of our own and societal attitudes that are often invisible, and being extremely self-aware. It is the kind of approach that is not just learned once and then used; it is a constant process of learning and refining.

Experience and research has taught us that survivors' lives improve in ways that most matter to them, i.e. being safer, happier and having healthy relationships, when they receive integrated services in which they can work on issues of violence, mental health and substance use with the same worker.[1] In one study, in terms of reduction of symptoms, the most significant improvement that women experienced through integrated services was a reduction of posttraumatic symptoms and drug use severity. Women who simply received increased services from a variety of practitioners (anti-violence, mental health and substance use) had *fewer positive outcomes* than the women who received integrated services. Women want spaces where they can talk about the totality of their experiences. For example, as a woman prepares to testify in court, she wants to be able to talk about her panic attacks and to strategize about how to manage them. This woman may also be concerned about how she will be able to show up for court without using, when she knows that her drug use is how she manages stressors in her life. These are all conversations we need to be able to have; it is our work. In every conversation we have with women, we are also cognizant of the impact of social location on her experiences of systems and simply being a woman in the world. Creating a safe and effective working relationship with a woman means supporting her in naming her experiences of societal oppression, acknowledging its impact and honouring the ways she maintains strength and dignity for herself.

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1   This was one of the significant outcomes from a five year study undertaken by SAMHSA, in which women who were survivors of multiple forms of violence and who had mental health and substance use issues as well as many societal barriers (poverty, illness, disability) received integrated counselling. For more information see *http://mentalhealth.samhsa.gov/nctic/sponsored_initiatives.asp*

1.3.1 Societal Beliefs About Women with Mental Health and Substance Use Issues

Mental Health Issues

Crazy. Schizo. Mental. These terms conjure up such scary images. We might picture women who are out of control, violent, dangerous.

And technical terms might not be any less loaded. Highly dissociative. Dissociative identity disorder. Delusional. Borderline. What do these labels mean? What do women with these labels look like? Act like?

"Mental health issues" is a broad term: it can apply to a range of experiences and behaviours, and underlines the fact that mental health is more of a continuum, as opposed to there being a clear line between health and illness. Using this term can help us to think about what we see as a mental health issue and what we see as a "normal" response to trauma and to consider whether we may have our own mental health issues, even if we don't think of ourselves as crazy.

Women and Mental Health

We believe that it is impossible for women to experience trauma without having some sort of mental health issue as a consequence. A woman who experiences violence may be depressed, anxious or angry for a period of time afterwards, or she may suffer for the rest of her life from intense flashbacks, chronically high levels of fear even in safe situations, or the belief that she is always being followed or watched. The impact of trauma on mental health cannot be predicted, and depends on the type of trauma, the age at which the trauma occurred, the relationship between the victim and the offender, body chemistry, past experiences, the level of support she received immediately following the trauma and her current level of support, and her use of legal or illegal drugs.

Feminists have fought against the psychiatrization of women for decades. It is not uncommon for doctors, psychiatrists, counsellors or other health care professionals to give a woman a psychiatric diagnosis if she is experiencing mental or emotional distress. Historically, many have not taken into account factors such as violence, trauma, poverty, oppression or other possible reasons for her struggle. Feminists and others have criticized this trend, and argue that many women have been labelled as mentally ill when in fact they are suffering from the results of trauma or oppressions such as sexism, racism and poverty.

It is also important to keep in mind that many women experience mental health issues that are not caused by trauma or oppression. These women may benefit from psychiatric diagnoses and medications. Women with existing mental health issues are more likely to be abused than other women, and abuse will exacerbate these issues.

> Nineteenth century diagnoses of "hysteria" assumed that a uterus and ovaries somehow placed women at risk for "nervous" disorders. On this basis, it was argued that women were unfit to vote, be educated or otherwise participate equally in society (Ehrenreich and English 1978 in Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

As frontline anti-violence workers, we must remember that it is not our job to diagnose women. It is not part of our work of supporting women and helping them to be safe. And it is not our area of expertise. However, it is part of our job to know (if she wants to share this information) about a woman's existing diagnosis or

diagnoses. What diagnosis does she have? Who gave it to her? (For example, we know a woman who was diagnosed as paranoid schizophrenic by a police officer and this label has stuck with her for years.) What does she think of the diagnosis? What does it mean to her? Does it fit for her?

You can research her diagnosis to make sure you understand it and its possible implications. But it is crucial not to see the woman through her diagnosis. It is a label that she has been given, not the core of who she is. You need to focus on whether and how this diagnosis will affect your work with her (see section on Definitions of Main Mental Health Diagnoses for more information).

Reflective Questions. What is society's view of an ideal woman? How might this view affect a women's mental health? What fears arise when a woman with mental health issues has children (society's fears, the woman's fears, your fears as a worker)? How have these fears manifested themselves in attitudes towards women you have worked with?

Discrimination, Prejudice And Mental Health

- One person in five in Canada will have a mental health problem during their lifetime: over 6 million people (BC Partners for Mental Health and Addictions Information 2006).
- Data collected in Manitoba and Quebec "shows that substantially more women than men received a diagnosis of a mental health problem and of an anxiety/depressive disorder and that more women than men received a psychotropic or an anti-anxiety drug or antidepressant" (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).
- Numerous studies have shown that there are strong and complex connections between women's experiences of violence and trauma and their level of mental health (Hiday, Swartz et al 1999; Jacobson and Richardson 1987).

Many of the problems that people with mental health issues face are directly caused by the impact of discrimination on their lives. For example, unemployment rates for people with mental health issues in Canada lie at between 70 and 90%, depending on the severity of a person's issues. Lack of decent employment and educational opportunities result in higher rates of poverty and a loss of socio-economic status, often long after symptoms of distress or illness have been treated or supported.

Increased likelihood of victimization is another risk for people with mental health issues: they are more likely to be a victim rather than a perpetrator of violence towards another (Hiday, Swartz et al 1999). Teplin et al (2005) found that violent crimes against people with mental health issues were, on average, 11.8 times higher: rape and attempted rape were 22.5 times higher and sexual assault was 15 times higher. This fact largely goes unrecognised. In fact, individuals with mental health issues are more likely to be treated badly by the police and criminal justice system than those without this additional vulnerability.

The personal costs of living with a mental health problem in a discriminatory society are huge. A 2001 Canadian study conducted with people diagnosed with schizophrenia found that social withdrawal had a much more substantial impact on their lives than the symptoms of their mental health problem (Schizophrenia

Society of Canada). Social withdrawal, and the consequent isolation this causes, leads to increased loneliness, alienation and feelings of rejection and emptiness. These experiences make recovery a lot more challenging. Many people also internalize the stigma associated with mental health problems and feel very negatively about themselves, developing low self-esteem and self-worth, and harbouring guilt and shame concerning their issues (CMHA 2007). They may feel under pressure to hide their issues, withdraw from personal, social and community structures and supports, and be reluctant to ask for help. This can lead to additional isolation and distress.

> As a society we have done much to alleviate major clinical symptoms of mental illness, but little to alleviate the symptoms of societal discrimination (www.heretohelp.bc.ca).

1.3.2 Mothering and Mental Health

Historically, women with mental health needs, or mental disabilities, were forcibly sterilized under the banner of eugenics and pursuing genetic purity. While this practice is no longer viewed as acceptable, there are many subtle and not-so-subtle ways that women with mental health issues are encouraged not to have children. Reasons given for this discouragement are due to their presumed psychological fragility, presumed inability to provide a stable home environment, and fears about passing on mental illness to another generation (Hamid-Balma 2004). A UK survey of people who use mental health services reports that 48% of women, and 16% of men, believed that their parenting abilities had been unfairly questioned because of their service user status (Reid and Baker 1996).

> The day-to-day struggles of women with mental health concerns who are mothers, and the strengths they display in managing all the demands on them, are largely invisible (Morrow 2004).

Support workers with good intentions may suggest that a woman put her children in care or have a family member care for them in order to ease her responsibilities while she deals with a mental health issue. This can be dangerous for women in terms of their rights to custody afterwards. In divorce proceedings it is common for a woman's mental health condition to be used as grounds for giving custody of the children to the father (Judas 2004).

Research indicates that women with mental health concerns often place a high value on parenting and that a woman's ability to maintain a relationship with her children is often critical to her recovery (Morrow 2004). To mother successfully, some women with mental health issues require additional supports such as advance planning and Ulysses Agreements that can help her plan for the times when she is unable to care for her children (Morrow 2004; for more information see The Representation Agreement Act, Ulysses Agreements and Advance Directives).

This is a prime example of why it is important to consider women's behaviours, as opposed to diagnoses or labels, when helping them to address their mental health issues. Is the woman behaving in a way that threatens her children's safety? Or does she simply have a label that carries negative connotations with it? (More on behaviours later in this section).

In the public policy arena too, an interest in mothers in crisis is often absent, concealed by a public focus on the rights and safety of children (Morrow 2004). The study *A Motherhood Issue: Discourses on Mothering under Duress* (2002) examined three situations of mothering most likely to be scrutinised by the mental health and child welfare systems, and where mothers were most likely to lose their children to the state:

- Women who were using substances while pregnant or as mothers
- Women who are mothers and experiencing relationship violence, and
- Mothers with mental health issues.

See the end of this section for resources on parenting with mental health problems.

1.3.3 Substance Use Issues

As humans, we seek out pleasure, or relief from pain, as do other animals. We have the technology to do this in many different ways, including the use of legal and illegal substances. We often become dependent on the method that works best for us.

> **D**rug addiction is not a disease but a way of adapting to desperately difficult situations. People cannot be "cured" of adaptive strategies unless better alternatives are available to them (Alexander 1990).

Although the use of mood-altering substances has been a feature of human societies for thousands of years, and many of us use a variety of them today, addiction is still considered by the majority to be caused by a moral deficiency or lack of willpower. The dominant attitude towards people who have addictions is that they can just stop their drug or alcohol use if they really wanted to. People who use substances are often viewed as unruly, out of control, aggressive, inconsiderate, selfish, irresponsible and involved with crime, based on the notion that "drugs are bad and so are the people that use them" (The Stella Project 2005). They are held responsible for their problems and blamed. However, substance use only became criminalized in the last century and many people can and do use substances in moderation with few problems.

Not all substances are equally harmful. Indeed, many factors affect the impact of a substance on a person and their life, including individual health status, levels of exposure, combinations of use and related risk behaviours (Poole and Dell 2005). Risk is therefore subjective and mostly related to factors beyond the substance itself. Licit substances, including psychotropic medications, also have significant effects that people who take them are not stigmatized or blamed for in the same way. An exception to this is the use of and withdrawal from benzodiazepines.

> **L**ess than one third of Canadians seek help with mental health or substance use issues (Statistics Canada 2003). Prejudice and discrimination are known to affect treatment behaviour, from attendance at self help/therapy groups to taking medications, with evidence that even a person's degree and speed of recovery is influenced by the negative attitudes held about them (www. heretohelp.bc.ca).

Women and Substance Use

Although there are commonalities between men and women when it comes to use and dependence upon substances, there are also many differences. Rates of use for different drugs, the biological impact of substances, the risk factors, the nature of substance use related issues, and recommended responses, are all different for women and men (CCSA 2007). In general, women are less involved with substances than men, a fact that has led to substance use/addiction services being focused, to a large extent, on male clients.

Women who use substances have traditionally been viewed as deviant and undesirable: "by taking substances they are no longer replicating the desired role of women in society" (The Stella Project 2005). This may be truer in cases where the substance use is quite visible and makes a woman's behaviour loud, erratic or otherwise unusual. However, in many cases substances actually tend to make women more subdued and withdrawn, thus more "normal," according to stereotypes of the ideal woman. In these cases, substance use may go unnoticed.

> **W**omen who are heavy substance users rarely use a single substance (Poole and Dell 2005).

The traditional approach to women who use substances has largely failed to make the connections between the use of substances and the reasons why women may use them. There is now evidence from women, practitioners and research that clearly describes the connections between women's use of substances and their experiences of violence, abuse and trauma and of dealing with wider challenges such as poverty, unemployment, discrimination, pressures of caring for children and dependent others, lack of work and educational opportunities, and low status in society. According to Poole (1997), substance use patterns are influenced by a partner's substance use, social isolation, stressful life events such as a death in the family, and the challenges of living in poverty. Other advocates concur that women's substance use patterns need to be understood in relation to a number of contextual issues such as high incidence of physical and/or sexual abuse as a child, sexual assault or relationship violence as an adult, lack of social support, low self-esteem, stigmatization, need for social services and child care, need for support and education around parenting, relationship counselling, coping skills training, and vocational and legal assistance (Kearney 1997 in Rutman et al 2000).

High rates of violence in relationships, mental health issues, sexual assault and historical child abuse and child sexual abuse are common experiences for women with problematic substance use, suggesting that many women deal with these stressors by using substances. This practice is sometimes described as self-medication. For some women the substance use may help them to cope with recurrent flashbacks or triggers in daily life that remind them of the trauma and result in overwhelming emotional responses. Women who experience violence in relationships are also much more likely to misuse prescription drugs, alcohol and illegal substances than women who are not in violent relationships (The Stella Project 2005). For example, a US study of shelters showed that as many as 42% of the women in those shelters used alcohol or other drugs (Bennett and Lawson 1994).

This said, trauma symptoms arising from past violence, and the absence of a safe environment, are major obstacles to treatment and recovery (Brown 2000). Trauma survivors often feel that service providers are not safe or trustworthy, or that they will lose their children if they seek out services and treatment (which they often do) (Moses et al 2003).

> **R**eflective Questions: Can you think of any ways that a woman with mental health or substance use concerns might consider your service unsafe? If so, how could you address this to increase safety for women?

> **"** I was darned lonely. I had no friends. I had nobody to talk to. So I started smoking more, getting high more often, with every aspect of the abuse, between the isolation, the physical abuse, the sexual abuse. This way I didn't feel any pain. I didn't feel any guilt. I didn't feel anything. I didn't want to feel" (Woman survivor quoted in Bland 2001).

One of the dominant myths surrounding women's substance use and relationship violence is the belief that their substance use caused the violence. This is not the case (Jacobs 1998), and it is now the established viewpoint, supported by research in the US and the UK, that women who experience relationship violence and who abuse substances are often likely to do so as a consequence of their abuse (The Stella Project 2005). Certainly, in the context of relationship violence and abuse, many women describe using substances to cope with and ameliorate the impact of this on their lives and to numb the emotional and physical pain:

> **"** I used to forget life, everything, to escape from every day... It just created more problems, a never-ending circle.... I look at the use of substances, stress levels and the experience of violence as all facets of the same problem, they are all connected."
>
> "Hopelessness, escape, putting off what I have to deal with. It's the way I tolerate a situation. It's a reprieve... It helps me stuff and not deal with anger but it also helps me blow off my anger. I stuff up my anger so much that when I blow up I am insane and not able to deal with it. I'm afraid of what I might do. I have drank many times in my life to cope with feelings of abuse" (Greaves et al 2006).
>
> Reflective Questions: Do you know a woman whose substance use makes her more "normal" and able to fit the expectations others have of her? Why is self-medicating with alcohol and illicit substances so highly stigmatized compared to using prescribed medications that often do the same job?

1.3.4 Substance Use, Pregnancy and Mothering

> *"Many adults have times when they suffer from anxiety or depression, have relationships with partners that are unstable, drink alcohol, and increasing numbers have used drugs, both licit or illicit, but this does not mean they are poor parents. It is the extremity or combination of these situations, particularly the association with violence, which may impair children's health and development" (Cleaver et al in The Stella Project, 2005).*

Mothers receive overt criticism if they use substances, and are often faced with additional barriers in accessing services for their needs. Since the 1980s, substance use during pregnancy has been viewed as a substantial problem by policy makers and social commentators in the US and Canada, primarily because of the adverse effects on fetal development (Rutman et al 2000), and increased efforts are now being undertaken to identify substance-using mothers. It is estimated that 6-20% of all pregnant women use alcohol or drugs while pregnant (Motherisk 1996 in Rutman et al 2000), although numbers are difficult to determine accurately because screening for alcohol and drug use is not consistently done. Some studies also suggest that women

tend to under-report their use for a number of reasons including shame, fear of losing their children, lack of understanding of the effects of use on the health of the growing fetus, lack of childcare and access to treatment (Rutman et al 2000).

Reflective Questions: What are the fears concerning women, substance use and mothering? How does the idea of women using substances disrupt our view of the perfect mother? What evidence is there to support the reality of these fears?

Many barriers exist that limit the ability of women with substance use issues to access treatment, support and care, including:
- Fear of the child's apprehension by child welfare authorities
- Contradictions between abstinence and harm-reduction approaches
- Lack of fit between existing treatment options and pregnant women's needs
- Lack of availability of treatment when women seek or need it
- Inflexible rules and inaccessible care
- Unsupportive attitudes of practitioners
- Lack of resources that enable women to get to treatment (Rutman et al 2000)

Another possible barrier that a pregnant woman or new mother may face is violence and control in her relationship and the impact on her mental health and substance use. One in six pregnant women are abused during pregnancy (Middlesex-London Health Unit 2000). Twenty-six percent of new mothers between the ages of 13 and 17 experienced violence three months after the birth of their child (US General Accounting Office 2002). Pregnant women who are abused by their partners have a higher risk for alcohol and illicit drug use, depression and suicide attempts (Ibid). Homicide is the leading cause of death for pregnant and recently pregnant women, the majority of whom are killed by their intimate partners (Horon and Cheng 2001). The intersection of violence, mental health and substance use in pregnant women's lives is prevalent and the lack of inclusive and non-judging services is a critical barrier.

There is also a lack of viable childcare options while women seek or access treatment. Additionally, misunderstanding exists amongst many professionals of the impact of some substances on fetal and early childhood development, especially methadone.

While women's bodies are constantly under the gaze of medical and public scrutiny, when a woman is pregnant this scrutiny is heightened: "women's individual responsibility for the outcome of their pregnancies places a burden on them that is unrivalled in any other area of parental responsibility" (Boyd 2004).

There are very few services in BC that offer non-judgemental services for women with substance use who are pregnant or mothers. Exceptions are Fir Square at BC Women's Hospital and Health Centre in Vancouver, Sheway in the Downtown Eastside of Vancouver, and The Maxine Wright Centre in Surrey. These services all use a non-judgmental, empowering, strengths-based, harm reduction and women-centred approach. Women who participate in these types of programs have lower stress and are better able to stabilize their family situations, while their children show significantly lower infant mortality and higher birth weight, and are

more likely to be full term babies (Public Health Agency of Canada 2007). It needs to be stressed that these services are all urban based and services like this are not locally available for rural, isolated women.

Because of the widely held presumption that equates all substance use with harm to the developing fetus, substance use during pregnancy is commonly associated with child abuse and many mothers have lost custody after birth once their substance use is confirmed: "mothers-to-be are transformed into 'pregnant addicts' who are considered at best sick and at worst criminal. They are identified as 'those bad mothers' who do not adhere to the predominant ideologies of motherhood, and as such are caught up in practices that seek to 'treat' or 'punish' them" (Rutman et al 2000).

The idea of "good" or "bad" mothers is also replicated in charged fetus versus mother's rights debates that in the US has caused some commentators to suggest that: "the war on drugs has turned into a war on women" (Whiteford and Vitucci 1997 in Rutman et al 2000). However, as Rutman et al challenge, there has been no parallel critique or commentary on the situation of woman assault during pregnancy, and the consequent potential for damage to the fetus as a result; they argue that the mother-blaming focus of much of the public and policy commentary is an attempt to police and control women's behaviour.

1.3.5 Concurrent Disorders: The Double Whammy

"Concurrent disorders" is the term now used to describe the combination of mental health issues with substance use issues. "Dual diagnosis" used to be the favoured term and is still used occasionally in Canada but has largely now been replaced. Sometimes people with mental health concerns use substances as a way of treating their symptoms and distress. This has been described as self-medicating. For other people, the substance use may trigger the onset of mental health issues. This tends to happen when an individual is particularly vulnerable to developing mental health issues. Whatever the reason why an individual has both challenges, the reality of living with both creates huge difficulties, with additional barriers to be faced in accessing adequate treatment and housing and the stress of dealing with frequent relapses and hospitalisations. Some researchers also believe that combining drugs and alcohol with prescription medication increases the risk of severe drug reactions and the triggering or worsening of mental health conditions (*www.heretohelp.bc.ca*).

For those diagnosed with both mental health and substance use issues the stigma and discrimination experienced is pretty much a "double whammy," with anger, resentment and fear being the predominant public and social response, rather than compassion and support. The Health Canada publication *Best Practices: Concurrent Mental Health and Substance Use Disorders* (2002) documents the additional and severe stigma associated with having both substance use and mental health issues. Focus groups were held with current or former users of mental health and substance use services and many people commented strongly on the harmful and hurtful experience of being on the receiving end of judgemental attitudes. The following quote has been taken from these sessions:

> *"I would really like to say the threat of being punished for being an addict and having any sort of mental illness, there always seems to be this threat hanging over that we are in some way responsible for this, we brought it on ourselves, and if we don't do A, B or C then our children will be taken and our welfare will be cut, our housing will be gone...There's just such an extraordinary threat and that just absolutely adds on to already extraordinary pressure, and I mean it's very demoralizing."*

According to Kaur (2004), those who experience both challenges: "have so internalised their shame that they often feel unjustified in speaking out for their rights." This makes them additionally vulnerable to having their rights violated in many domains.

> **R**eflective Questions. Think of a woman you have worked with who had mental health and substance use concerns. What would she have said about the connections between the two? How did these additional challenges affect her safety? How did these additional challenges affect your work together?

1.3.6 Interconnecting Oppressions

The general prejudice and discrimination against women with substance use and mental health issues interconnect with other oppressions including heterosexism, racism, poverty and ableism. The connections between these elements are too numerous and complex to fully cover here, and each woman's experience will be different. Here are just a few examples of interconnections:

- **Colonization and substance use:** Aboriginal communities in Canada have been deeply damaged by colonization, residential schools, racism and poverty (see section on Particular Barriers to Safety for Aboriginal Women on Reserve in Safety and Support for Women in Rural/Remote Communities Who Are Dealing with Violence and Substance Use for more information). The rates of substance use among Aboriginal people are higher than the general population and Aboriginal women on and off reserve will face specific barriers to dealing with substance use issues.
- **Mental health and heterosexism:** In 1973, homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM II) by the American Psychiatric Association. Until that time, and afterwards as well, gay men and lesbians were often institutionalized in Canada and the United States because of their sexual orientation. Lesbians and gays still risk institutionalization in other countries. Older lesbians and immigrants may have histories of psychiatric treatment because of their sexuality, and some younger women may also have experienced forced treatment, depending on their families' and doctors' perspectives. There are still widespread mistaken beliefs that lesbianism results from traumatic experiences with men, sexual abuse or other psychological trauma.
- **Mental health and transphobia:** The inclusion of Gender Identity Disorder in the DSM IV by definition labels any individual with a cross-gender identity as disordered or deficient. It reinforces stereotypical expressions of gender and does not recognize that gender variant individuals may be well adjusted and not require treatment from the mental health system. Gender Identity Disorder was expanded in the DSM IV to include children, which pathologizes normal childhood exploration of identity, roles and behaviours.
- **Poverty, ableism and health:** In BC the rate of poverty among single mothers has risen dramatically, due primarily to income assistance cuts and policy changes resulting in limits on what kinds of disability will be recognized for greater income exemptions. With 49% of all single mothers living in poverty (CCPA 2006), an increased number of women are homeless, engaged in survival sex, vulnerable to exploitative relationships and not receiving adequate health care.
- **Substance use and heterosexism:** For decades, lesbians and gay men have struggled to find places where they can meet in safety. For many lesbians, bars are an important part of life, a place where they can gather with friends and lovers. It may be difficult for a lesbian who is deeply involved in the bar culture to strategize about quitting drinking. It is important to understand the role that the bar may play in her life.

Whenever we work with a woman, we need to understand her experiences of violence, mental health and substance use in the context of living in a society that discriminates against and blames her for these experiences and also discriminates against her if in any way she does not represent the dominant culture. Exploring with the woman her understanding of how this intersects in her life, how it impacts her ability to stay safe, to access the resources she requires and how she navigates these barriers in her life is central in the work we do.

Think about the five women below, and what your attitudes and societal attitudes might be about each woman. Who is seen as having an addiction, a problem, an issue? Who comes to the attention of the legal or mental health system? Whose substance use is not interfered with?

Catherine is a middle-class white woman with a good job and two children. She buys wine at the liquour store and drinks it every night. She is a single mother and has no close friends or family. She drinks to try to deal with the stress of an ongoing custody battle with her abusive ex-husband.

Edie is an Aboriginal woman who works in the sex trade and buys and injects heroin on the street. She has a long history of abuse and few trusted people in her life. Her children are in care. She has periodic angry outbursts in which she yells and threatens workers and other clients in the support groups she attends.

Marija is a new immigrant from Eastern Europe who has survived war trauma, including rape, and has vivid flashbacks and uses high doses of prescription medications to try to cope with them. She often believes that she is back in her home country or that people have followed her to Canada from her country.

Alisha is a teenaged African-Canadian woman who uses crystal meth at house parties and all of her friends use meth too. Her father is physically abusive to her and she is living part-time with her boyfriend, who sells meth.

Terry is a butch lesbian in her sixties who has been in psychiatric wards where she was "treated" for lesbianism. She would like to get help for her periods of deep depression but is fearful that she will risk being institutionalized against her will once anyone discovers her sexual orientation.

An invaluable resource for working with women on issues of violence from an anti-oppression perspective is Bonnie Burstow's book *Radical Feminist Therapy: Working in the Context of Violence* (see resource section for full reference). Burstow details anti-oppression work with survivors of the mental health system, with women who use substances and with survivors of all forms of abuse, and provides examples of inquiry that workers can use with lesbians, women with disabilities, Aboriginal women, Jewish women, Black women and immigrant women to unpack the impact of society's oppression on their experiences of violence and survival.

1.3.7 Why Anti-Violence Workers Must Address Substance Use and Mental Health Issues As Part of the Work with Women

Many women live with all three issues of violence, mental health and substance use concerns. In a study undertaken in the UK (The Stella Project 2005), all those with problematic substance use who accessed anti-violence services saw a link between their substance use and their experiences of violence. Almost two-thirds of these women reported that they began their problematic substance use following experiences of violence within their relationships. Sexual and physical abuse in childhood is also strongly related to problems with substance use. Girls and women who have been sexually abused are more likely to use substances, to use

them earlier, and to use them more often and in greater quantities (Poole and Dell 2005). Women who have experienced physical and sexual abuse as children are at increased risk for a range of mental health problems, including depression, posttraumatic stress reactions, suicidal ideas and attempts, eating problems, self-harm and psychosis (see Veysey and Clark 2004; this will be explored in more depth in the section Broadening the Lens and Moving Towards Empowerment).

Testimony from women, research and analysis shows that women living with mental health issues, substance use and trauma/violence are more likely to have more severe difficulties and to use services more often than women with any one of these problems alone. The help-seeking histories of survivors with complex issues of substance use, violence and mental health issues are also often lengthy and complicated. Without coordinated services, the danger is that women will only access one type of service, despite being affected by all three issues.

Despite violence, substance use and mental health being interrelated concerns in many women's lives, there has been poor coordination among mental health, addiction and anti-violence services. This is due in part to differences in service philosophies between these three sectors, with the mental health and substance use sectors often taking a more individualistic and treatment oriented stance in their work with women than anti-violence services, which tend to emphasize safety planning, emotional and practical support, counselling, empowerment and anti-oppression work.

Mental health services often refuse treatment to a person with an active addiction and addiction services can be unwilling to treat addiction until the mental health problem has been dealt with (Kaur 2004). Anti-violence services have also commonly refused to provide services to women with significant substance use or mental health issues. All three sectors have been guilty of having "silo" thinking, in which each worker believes it is not her job to deal with the other two issues in a woman's life. The result is that women may be involved in mental health or substance use services without ever talking about their experiences of violence or creating safety plans. And women involved in anti-violence services may never discuss the impact of medication on their safety or ability to function in life or be forced to hide their substance use for fear of being excluded from services. Many women continue to be referred between systems, never really getting the holistic help they need.

> *"For women with multiple vulnerabilities, particularly women diagnosed with serious mental illness who have been and/or are currently in abusive situations, and who use alcohol and other drugs, and may have a number of health problems, it is an overwhelming burden to navigate fragmented and competing systems. When a drug treatment program will not take a woman who self-injures, when a battered women shelter will not admit a woman who uses a drug, when a mental health program will not admit a woman diagnosed with serious mental illness with her children, when a medical provider speaks disrespectfully to a pregnant woman because of her substance abuse or doesn't listen to a woman ...attempting to discuss her abuse history because she 'is crazy,' then our systems and programs are doing harm"* (Brown 1997).

Because women who are problematic substance users have tended to be excluded from anti-violence services if they use drugs or alcohol, they have been particularly vulnerable to long-term experiences of violence and homelessness as they have fewer options of where to go for help, support and safety (The Stella Project 2004).

By refusing to work with women with substance use issues we continue the discrimination and consequent alienation and rejection that women face in many areas of their lives. Indeed, by not including them in our services we are in danger of excluding the women who most need acceptance and support to create safety and healing for themselves and their children. The Stella Project emphasizes that if we ignore drug or alcohol issues our clients may be:

- Less likely to leave a violent partner
- In greater danger of more severe violence
- More likely to have an ineffective criminal justice intervention
- More likely to lose their children
- Less likely to benefit from counselling
- Less likely to be admitted to a transition house or provided with permanent housing

Over the past decade there has been progress made in this area in Canada, the US and the UK, with each sector realising the need to work more closely with the others in order to provide a better service to their clients. There is now recognition in some services that all three sectors:

- Have an overlapping client base
- Have clients with similar psychosocial issues, such as guilt, shame, denial, depression and low self-esteem
- Address social exclusion and break down isolation

1.3.8 Tips for Working with an Anti-Oppression Approach

Whenever we work with a woman with substance use or mental health issues who has experienced violence, it is important to explore the reasons behind these issues. What has led to the substance use or mental health issue? How is it connected to the violence? Violence can be one traumatic event, a series of events, or a lifelong experience of oppression. When talking to a woman about substance use and mental health, we need to ask her and ask ourselves about how oppression may have affected her.

At the BCASVACP 2006 Annual Training Forum, Dr Laura S Brown, an expert on trauma, discussed the limits of our understanding of PTSD, particularly our understanding of it as resulting from one very violent incident. She shared some of the work of her colleague, Maria Root, who has developed the concept of "insidious traumatization." This is the cumulative experience of trauma often experienced by members of oppressed groups. Experiences of discrimination, knowledge of violence against others in your community, etc, can build up, as Dr Brown explained it, "like drops of acid on a rock, until one drop shatters it." (Dr Brown was a speaker at the BCASVACP's 2006 Annual Training Forum; DVDs of her speech are available through the BCASVACP and the video can be watched online at www.endingviolence.org.)

In general, the more privilege a person has in our society, the more they are able to hide their struggles. So, for example, a woman who is addicted to alcohol and who is white and has a home and a job will be less visible to the public than a woman of colour who lives on the street and uses heroin. The woman of colour who is on the street is more likely to face intervention from police and social workers and is more vulnerable to the scrutiny of the general public.

Foundations for Support Work

The following assumptions can assist us in developing a model of support for women living out the intersectionality of oppression, violence, substance use and mental health challenges (excerpted and adapted from *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*. Maxine Harris and the Community Connections Trauma Workgroup. New York: The Free Press. 1998).

Each woman is the expert on her own experience and her own healing journey.
Violence against women is the result of systemic oppression.

Many current dysfunctional behaviours and/or responses may have originated as legitimate coping responses to trauma or attachment issues.

Women who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills necessary for adult coping, including attachment.

Trauma severs core connections to one's family, one's community and ultimately to oneself.

Women who have been abused repeatedly feel powerless and unable to advocate for themselves.

Simply living in the body of an oppressed person is traumatic.

Building on these assumptions, we use a model of recovery that includes the following elements:

- Feminist anti-oppression analysis informs every aspect of our work.
- Safety is the most important goal, initially and throughout our work. Therefore, engaging in risk assessment and safety planning will be a priority.
- We try to ensure that her basic needs are being met and help her if she is unable to meet them herself; we advocate for her in the event her basic needs are not being met.
- We prioritize providing a safe place where she can come and be accepted as she is.
- We incorporate basic information on how systemic oppression of marginalized people contributes to and can compound women's experiences of trauma as well as negatively impact on their ability to heal/recover.
- We believe that trauma is disconnecting and that broken connections can only heal in the context of new connections, and therefore believe that trauma recovery is benefited by providing support work in a group format.
- We believe that attachment plays a significant role.
- We remember that profound mistrust and/or profound fear and/or psychosis (where a woman is having trouble getting a handle on what is real) may be less amenable to supportive, mid-range counselling and clinical treatment in general. See section on psychosis in Safety Planning for Women with Mental Health Issues for more information.
- We know that there is tremendous value in listening to a woman's experience, validating her feelings of fear, questioning what might be real and what might be a result of fear run amok.
- We include basic education about physical and sexual abuse and how current behaviours are linked to past abuses (impact of trauma).
- We reframe current responses as attempts to cope with unbearable trauma.
- We have an appreciation of the problem-solving attempts locked and hidden in certain repetitive behaviours.
- We include education focusing on basic skills in self-regulation, boundary maintenance, and communication.
- We include basic education about female sexuality and correcting misperceptions.
- We work to create a healing community by providing recovery services in a group format.
- We support rediscovery of and reconnection to lost memories, feelings and perceptions.
- We provide an opportunity for women to experience a sense of competence and resolution as they face the their past trauma.
- We provide an opportunity for women to trust their own perceptions about reality and to receive validation from others for those perceptions.

Self Reflection

One of the essential requirements for working in a non-oppressive manner is to be as self-aware as possible. As you begin or develop your work with women who use substances or have mental health issues, what comes up for you? What do you have in common with the women you work with? What biases and assumptions do you have? Remember, we all have biases and assumptions; we can get past them if we understand and stay aware of them.

It is not possible for us as anti-violence workers to come from an anti-oppression position if we see our clients as OTHER—as people with whom we have nothing in common. For example, if we believe that women who get into abusive relationships are stupid or weak, and we believe that we would never get into such a situation ourselves, we cannot have empathy for them. The same is true for working with women with mental health or substance use issues. We must be able to connect our own experience to theirs.

Our assumptions about substances and the women who use them might include:
- Drugs are bad. Women who use drugs are bad.
- Drugs are interesting and cool. Women who use them are cool unless they are too addicted to keep themselves together.
- Prescription medications are not bad, just the drugs you buy on the street.
- Alcohol is not as bad as drugs.
- Cigarettes and coffee are OK, because they are legal.
- Women who are addicted lack self-control.
- I have kicked my drug habit so everyone else should be able to do it in the same way and in the same timeframe.
- I have never had a drug habit so I can't understand these women. My addiction to coffee and sugar is completely different from their experience.
- Women who use drugs are criminals and should be dealt with that way.
- If women cared about their children, they would not use.

And about mental health:
- Mental illness is scary. Women who are mentally ill are violent, dangerous and unpredictable.
- Mental illness is a sign of weakness or laziness.
- Anyone can overcome mental illness if they try hard enough.

There also may be assumptions that are specific to anti-violence workers:
- Prescription anti-depressants are always harmful, and real feminist counsellors should tell clients not to use them.
- If a woman is using substances, she is doing what she needs to do to cope, and she will stop when she needs to. If I talk to her about it, it is interfering in her process.
- Mental health issues are a normal consequence of violence and can all be treated with counselling alone.

What are your assumptions? In this section and throughout the tool kit, we include suggestions about how to check in with yourself about your own biases.

Two-thirds of women accessing anti-violence services reported that they began their problematic substance use following experiences of violence in their relationships.

Reflective Questions:

Experiences of Discrimination
- Have you ever experienced stigma and discrimination? How did you feel? What could or did you do about it, if anything? Who was there to help?

Counselling and Support Work
- What individual characteristics result in you feeling uncomfortable or unsure of how to communicate with someone?
- What do you find most challenging in women you work with? Anger, extreme withdrawal, unusual thoughts and perceptions... What are your fears here?

Mental Health
- What have been the factors that informed your own personal views of mental health issues or mental illness? Do you have a friend or family member with mental health issues? What impact does it have on their life? How is their life different because of this, if at all? How has knowing them made a difference to your views about mental illness and mental health?
- Have you ever experienced depression or anxiety that disrupted your life? Have you taken anti-depressants or other psychotropic medication? Have you sought counselling? Have you been hopeless or suicidal? Have you worried about your own safety due to the state of your mental health? How do you feel about these experiences? Has anyone you loved or been close to had these experiences? If so what was the impact on you?
- What fears do you have about mental illness?

Substance Use
- What substances do you use regularly? Occasionally? In the past but not now? What are/were the positives to use? What are/were the negatives?
- Have you known friends or family with drug or alcohol problems? How did their use affect them? How did it affect others? You? What feelings does thinking about this bring up for you now? Do these feelings affect your work with women with substance use issues? Do you need to do anything to keep a check on this? What could you do?

Specialized Training

When workers are asked to work with women who have particular needs, we often say, "I need specialized training to deal with this." This may well be a valid response, but sometimes it arises from our fear of certain women—for example, women who are addicted to substances or who have mental illnesses.

It can be helpful to think of counselling and advocacy as having some key central tasks:
- Communicate with the woman
- Advocate for and with her
- Contextualize her experiences
- Empathize with her
- Assess her needs

If we come from a place of asking ourselves, "What do we need in order to do these tasks with a woman who has substance use or mental health issues?" this can help to normalize the work and lessen our "othering" of certain women.

We may need specialized training about mental health diagnoses or the effects of legal and illegal drugs. However, our core questions should be about how to do our central tasks most effectively with all women who come to us for services.

For example, I am working with a woman who believes that people are following her everywhere. She does not bathe or change her clothes very often and has a strong body odour. She often says things that I cannot understand and talks quickly and loudly. Sometimes she seems to see things that are not there. This is all challenging for me. Do I need specialized training? Or will it be helpful to focus on how I can communicate most effectively with her?

What does this raise for me? What fears do I have? What strengths can I identify? (See the Psychosis section in Safety Planning with Women with Mental Health Issues for more information.)

Engaged Neutrality

Sometimes we resist working with women who face multiple challenges because we fear we do not know how to help her, and at some level we struggle with our fears about what happens to her when she leaves our office. It is risky to care about someone who is so at risk in the world. We fear that if she is badly hurt, we will feel pain because of our emotional involvement with her: we will suffer because of caring about her. We may also have conscious or unconscious worries that a woman will not "succeed." She will not leave her abusive relationship, stop using or achieve mental health. This "failure" will cause us pain and perhaps reflect badly on our work.

Particularly when working with high-risk women, we need to be careful about our own boundaries and the expectations or pressures we put on ourselves and on our clients. We cannot decide what success looks like, and then impose that definition on her. She needs to be at the centre of any plans for her life. If she determines goals for herself and does not meet them, we need to make sure that we have not created a personal investment in her acting in a certain way.

This is where the concept of engaged neutrality comes in. We can work with our clients in an engaged, caring manner; we can be concerned, worried or happy for them. However, if our own satisfaction with our work depends on our clients' actions, this is a set-up for failure. A client may feel pressure to please you, you may lose perspective on her situation, and you are more likely to feel negative and stressed about your work. So neutrality does not mean not caring; it means that we are not overly emotionally involved or invested. We take care of ourselves and meet our own needs for happiness or job satisfaction.

Notice your thoughts as you work with each woman. For example, if you are thinking, "She is hopeless," don't get mad at yourself, but just notice it. Then try replacing that thought with "I will do what I can for her," or something that works for you. It's important to acknowledge that we all have uncensored thoughts and judgements. It is essential to recognize these in ourselves, figure out where they are coming from and determine how we can work through them.

Success will look different for different women. For example, a woman who uses heroin and is homeless might completely stop using and find a job and an apartment. Another woman in that situation might cut down her drug use and find safer places to sleep at night. Another woman might continue to use heroin and live on the street and get some emotional relief from coming to appointments with you. This will depend on the barriers facing each woman: racism, poverty, history of trauma, etc. It will also depend on what each woman wants or is able to do. This is where our awareness of context and individual situations is essential.

An example of engaged neutrality: Use a harm reduction approach to open up room for important discussions. For example, asking a woman if she is open to hearing about suggestions for monitoring her blood alcohol level (fewer drinks spread out over more time, etc) could create an atmosphere where alcohol use can be discussed openly and honestly. There are practical ways to make substance use safer (see section on Moving Towards Safety: Using a Harm Reduction Framework for more information).

Asking and Listening

In order to work in a respectful, effective manner with each woman, we need to know as precisely as possible what is happening for her and what she needs from us.

It helps to look at situations through a safety lens: what concerns does the woman have about her safety? What concerns do I have about her safety? The questions that I ask help me to understand what is going on in the woman's life and how I can help her. I need to remember that I do not know whether or not a mental health issue or substance use is a problem. It is up to the woman to tell me about how it affects her life (see section The Importance of Safe Conversations: Identifying Risk and Resources for more information).

1.3.9 An Important Note About Questions

Intake procedures involve asking many questions, and questioning is a key safety assessment and counselling technique. As anti-violence workers, we have been trained to ask questions in a respectful manner. Working with women with mental health or substance use issues adds more layers to our questioning. We need to be very aware of our intent in asking questions. It is important to ask questions in order to find out how best to support her and to tailor our service delivery to her needs. We need to be careful not to ask questions for the purpose of pathologizing, categorizing or diagnosing her.

We can start by respecting a woman as an individual, before we begin asking her questions. The fact that she has come in to receive services does not give us the right to pry into her life. We need to be clear with her about why we are asking the questions and let her know that she can choose whether or not to answer. We also need to be clear in our own minds and with the woman, what notes (if any) we will make of her answers.

Using the Five W's and the H

If we say a woman has a mental health issue, or that she uses substances, this doesn't really tell us much about her experience. The key questions to keep in mind when approaching this work are the five W's: Who? What? Where? Why? When? And the H: How?

The context that we are working within determines which questions we ask. It is imperative for a worker to be clear what information she may need in order to assist a woman in the work she wants to do. What questions would we ask if we were working on increasing safety, versus being able to be present for court and be seen as a credible witness, versus supporting a woman in working through her history of abuse?

In each of these service delivery contexts, when supporting a woman who is using substances, we will need to ask some of the following questions, and others would not be appropriate.

Who?
- Who is she?
  - In her experience, how does her social identity (race, class, ethnicity, etc) affect her use of substances and access to services?
  - Who does she consider to be her community?
- Who supplies her with substances? Who uses with her? Is it someone who abuses her and/or forces her to use?
- Who lives with her?
- Who helps her when she is in trouble or faced with difficult situations? Who does she take care of and who will take over for her when she is at court?

What?
- What substances is she using? Are they legal or illegal?
- What are the consequences she has experienced using these substances? What are the possible risks?
- What is she concerned about (if she is concerned)?
- What does she have to do to obtain these substances?

Where?
- Where does she use substances?
- How much control does she have over the location?

When?
- When does she use substances—how often? At certain events? After certain triggers? During the day or at night?

Why?
- Why does she use? Is her partner pressuring or forcing her to use? Does the substance help her cope with emotions, memories, flashbacks, physical pain?

How?
- How does she use her substance? Injection? Inhaling? Swallowing?
- How does substance use affect her? Does it change her behaviour? Does it make her sick?
- Has it affected her employment, her housing?
- How do people around her react to her using? Family? Friends? Partner? Community? Society in general?

What is important is to focus our questions on practical information that helps us plan for greater safety or to reach the goals she has identified. The answers will help identify the areas in which the woman needs support or further exploration. The answers will likely illuminate the ways in which social identity affect her experience and how she is seen by society and service providers, which will guide us in our work with her (see sections on Broadening the Lens and Moving Towards Empowerment, The Importance of Safe Conversations: Identifying Risk and Resources and Safety Planning with Women Using Substances for more on asking questions).

Behaviours and Context
The reality is that labels may give us some clues to how best to support a woman, but what we really need to focus on is behaviours.

So a woman has been labelled as having mental health issues. What are her behaviours? What is she doing? What is she saying? How do her behaviours affect her? How does she understand her behaviours–what meaning do they have for her? How do they affect others? Where do they come from? In what context do they occur? What meaning can we draw from them?

For example, you are working with a woman who is convinced that there is a network of people who are following her. If we focus on the emotions we can see that she has a high level of fear. As opposed to focusing on debating the details of the story, how can we help her to manage her fear?

The challenge is to hear her experience enough to work with her on managing strong feelings and help her stay connected to practical strategies of staying safe, while neither affirming nor discounting her visions or beliefs. A reflection statement of "I know you are very scared right now, and I'd like to explore with you ways of staying as safe as possible while this is happening to you," may help the woman feel supported and move her towards what she can control (for more information see the section on Psychosis in Safety Planning with Women with Mental Health Issues).

Displaying anger is one of the most challenging behaviours for workers. We may be scared of anger, or resentful of it. Anger is very loaded for women and for survivors of abuse. We may classify all angry behaviour as abuse. It is valid for workers to expect that clients will not yell or swear at us, or threaten or hurt us, and it is also crucial that we see behaviours in context. If we are getting paid to work with a woman, and/or we have the power to refuse services to her, we have power over her. If she yells or swears at us, it is not abuse (a pattern of power and control). At the same time that we keep ourselves and the woman and other women safe, we need to pay attention to the cause of her anger. What is its source? Can we address the source of the anger now, or do we need to wait until she is calmer? What is possible? (See section Challenging Our Assumptions: Working with Women's Anger and Use of Violence for more information.)

Conclusion

The links between violence, trauma and oppression and mental health and substance use are deep and complex. As anti-violence workers, we must acknowledge and continue to explore these links. Our work with all women needs to come from a place of respect and non-judgment if we are to help them to feel accepted and supported and more confident in moving forward to live free from violence and discrimination. This is not always easy for us, but the dangers of responding to women with substance use or mental health concerns from a place of fear, ignorance or trepidation are clear. Women will continue to hide their problems from those who may be able to help, placing them and their dependents at even greater risk. Responding instead with openness, tolerance, compassion and understanding will surely be a better support to them on their journey. Women with mental health and substance use concerns continue to remind us that it is by being treated with dignity and respect that they are able to come to accept themselves and begin to heal.

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SAMHSA's National Mental Health Information Centre
http://mental health.samsha.gov

Parents with Mental Illness: Their experiences and service needs
Cook, J. A and Steigman, P.
http://www.psych.uic.edu/UICNRTC/Parents.PDF

Parenting well when you are depressed: A complete resource for maintaining a healthy family
http://www.parentingwell.org/book.html

Postpartum Support International
http://www.postpartum.net

Selected readings pertaining to mothers with mental illness and their children
National Research and Training Centre on Psychiatric Disability
University of Illinois at Chicago
http://www.psych.uic.edu/UICNRTC/Readings.PDF

Making time to talk: Advice for parents with mental illness
NSF Scotland
http://www.nsfscot.org.uk/search/index.html

1.4 Broadening the Lens and Moving Towards Empowerment

BY TESSA PARKES

"I like it when people ask me what I want, particularly if I am taken seriously when I speak out. My old treatment team hated me. I argued with them all the time, and sometimes I got violent and threw things at them. The main problem was that we always disagreed, and I never got what I wanted. The old team reminded me of my family. They acted as if they knew what was best for me, but never asked how I felt or what I wanted. Believe me, I will fight tooth and nail against people who remind me of them. I care about being respected, and I demand to be taken seriously" ("Darlene" in Harris and Fallot 2001).

1.4.1 Trauma, Mental Health And Substance Use: Responding To The Connections

There is now substantial evidence that the stress caused by past or current/ongoing violence can affect all aspects of a person's life, including their emotional, mental and physical health and wellbeing. For women with abuse histories, the risk of developing mental health problems as an adult is heightened. This is true for depression, posttraumatic stress, suicidal ideation and attempts, poor self-esteem, eating disorders, self-inflicted injury, and psychosis, as well as for chronic medical conditions (Bassuk et al 1998; van der Kolk 1996; Herman 1992; Alexander and Muenzenmaier 1998; Reid et al 2005). Research shows that prolonged trauma may disrupt and alter brain chemistry, leading to the development of PTSD (see Herman 1992; Haskell 2003; Levine 2005). In addition to this, mental health problems such as depression, suicide attempts and self-harm are frequently symptoms or effects of abuse. Pre-existing mental health problems can also be exacerbated by abuse and violence in adult life. This subject is picked up again in the section on safety planning with women with mental health problems. (For further information on the connections between trauma, mental health and substance use please, see the references and resources at the end of this section and the BCASVACP's *Best Practices Manual,* McEvoy and Ziegler, 2006. For information on PTSD and trauma/mental health links see www.sidran.org).

Sexual and physical abuse in childhood is also strongly related to problems with substance use. Girls and women who have been sexually abused are more likely to use/misuse substances, to use them earlier and to use them more often and in greater quantities (Poole and Dell 2005). A significant proportion of women using transition houses, sexual assault centres and related anti-violence services experience problems related to substance use (Greaves et al 2006).

Despite these links, mental health and psychiatric services have historically ignored the connections between violence, trauma, mental health problems and substance use. This continues to the present day and is reinforced by the dominant bio-medical approach to mental illness and distress that looks for causes other than social and environmental factors. These services have also largely ignored the role played by other social inequalities like poverty, low social status, and the burden of care giving on women's mental health.

Women with mental health or substance use concerns have shared over and over again that what helps them is caring, supportive and safe relationships, and that these relationships are often not found in traditional health, mental health and substance use/addiction services. Particularly in a system that is increasingly drained of resources, women report having to wait months for an appointment with a psychiatrist and then having fifteen minutes to meet with them. Unless they access a community-based mental health or substance use/addiction service, women rarely are given space to talk about anything other than their mental health or sobriety. Women with long term service use and trauma histories are often perceived by the systems that serve them to be:

- manipulative
- controlling
- difficult
- immature
- attention-seeking
- secretive
- suspicious
- devious
- masochistic
- untreatable
- personality disordered (Inequality Agenda 2005)

Women survivors of abuse and violence with mental health and/or substance use concerns often internalize these stigmatizing views of themselves.

In addition to this, many commonly used mental health and substance use practices can trigger memories of prior traumatic experiences as well as traumatic stress responses to the practices themselves; for example, the use of:

- physical control and restraint procedures
- seclusion
- forced medication

In substance use settings the strongly confrontational approaches that have traditionally been used, which do not respect or support a women's right to go at her own pace with reducing substance use, can damage her fragile coping mechanisms and make her want to abandon her treatment efforts (Moses et al 2003). Be alert to the likelihood that a woman you are working with will have been retraumatized within mental health and addictions services, particularly if she has had extensive use of these services and has a history of childhood abuse.

> **"**I don't remember everything that happened before I was last hospitalized, but I do know that I had a lot of problems. I was experimenting with a lower dose of medication because I didn't like the side effects, my boyfriend was beating me up and my roommate had stolen my money. My case manager showed up with the police to take me to hospital. I hate the hospital, and I hate the police. Basically I like to be in charge of myself" ("Barbara" in Harris and Fallot 2001).

Remember that many women with histories of using mental health services are mistrustful of staff and providers–not only within mental health services but also within all so-called "helping" services. This mistrust is often rooted in their experiences of coercion, retraumatization and degradation during their use of services. This must be kept in mind when talking to women about their mental health or substance use issues and care must be taken to avoid using language or practices that continue this disempowerment.

1.4.2 Supporting A Woman On Her Empowerment Journey

"The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the woman and the creation of new connections" (Herman 1992).

Human relationships are key to the healing process; particularly ones that are based on safety, value, respect and trust, that help women learn what they need and develop strategies for change. Traditionally, in the mental health system the treater is the expert, whereas in an advocacy system the survivors are the experts: this is central to the concepts of recovery and empowerment. An advocacy role means not viewing ourselves as experts on a woman's situation or on her choices.

For women who have disruptive or painful mental health symptoms, framing these symptoms in the context that contributed to them is essential. This helps to demystify and destigmatize these experiences. Asking a woman questions like: "What has happened to you in your life that has had an impact on your emotional health/ mental health/anxiety/unhappiness?" can be helpful in this framing work (see below for more examples).

Women need support to build new skills to recover and heal from violence, trauma and abuse as well as from the negative impact of mental health problems, inadequate or pathologizing service provision and problematic substance use/addiction. The following skills are important ones to help a woman feel empowered[1]:
- Increase self-knowledge
- Enhance self-regulation and self-soothing
- Build self-esteem and self-trust
- Develop interpersonal skills such as limit setting and assertiveness
- Learn how to more clearly express and communicate her needs and desires
- Perceive others and situations more accurately
- Work towards mutuality and reciprocity in relationships
- Enhance her parenting and life skills (Harris and Fallot 2001)

Another key way in which anti-violence workers can diminish a woman survivor's feelings of helplessness, and increase her sense of empowerment, is by increasing her range of choice in all aspects of her life, not just the aspects directly related to the violence she is currently experiencing. Discussing options and choices are therefore essential activities that can help women empower themselves. Helping a woman develop stronger self-capacity is also one of the most effective ways of helping trauma symptoms and frequent crises. The more a woman survivor is able to...
- recognize, tolerate, modulate, and integrate her feelings
- feel internally connected over time to caring others
- feel deserving of life, love and attachment...

...the more she will be able to manage life and relationships, and to manage feelings and memories in particular (Inequality Agenda 2005).

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1   While these skills should enhance safety for women in their lives and in relationships, limit setting and increased assertiveness may make a woman less safe in the context of an abusive relationship.

> **U**se the acronym RICH to remember the four most important things you can offer: respect, information, connection and hope (McEvoy and Ziegler 2006).

1.4.3 Questions To Ask To Broaden The Lens

"If a woman is immobilized by depression or panic attacks, treatment is clearly warranted to help her be able to function and make choices that will ultimately lead her to safety. However, reframing these 'disorders' as understandable responses to terror and entrapment leads us to a different set of intervention strategies and helps us keep our focus on the real dangers she faces" (Brown 1997).

Keeping in mind what we said in the previous section on the importance of developing a relationship with a woman before asking questions, and being clear regarding our intent in asking a question and the context in which we work, we have provided sample questions to consider asking a woman who has violence, mental health and/or substance use concerns. We have not included specific questions about violence because the assumption is that these will always be asked as part of your work with a woman. This list is intended to provide you with some ideas about how to invite an exploration of the possible influence of mental health issues and substance use issues on a woman's life. Counsellors and outreach workers would likely use more of the questions than a Community-Based Victim Assistance worker. But for all workers, it is beneficial to use some questions to help understand what gets in their way of safety (or dealing with the legal system). These questions aim to help us to see the complexity and interconnectedness of many life challenges and to keep the focus of our work clearly on supporting women's self-efficacy and empowerment.

Here and Now
- What do you see as the most important issue you need support with now?
- What risks and dangers are there in your life now?
- What additional stressors are you experiencing at the moment, unrelated to the abuse (problems at work, ill child at home)?
- What would you most like to change in your life right now, if anything? Have you thought about how you may be able to make this change? What barriers are there to making this change? Do you have ideas about how to get over these barriers?
- What additional support or resources do you most need right now?
- How can I help or support you now? Please let me know if this changes.

What Helps and What Harms
- Did you receive any help with surviving or coping in the past? What support was helpful to you?
- What are you doing to keep safe at the moment? What else do think would help you keep safe?
- Did you find any particular agencies helpful in the past? What or who was helpful in particular?
- Have any services gotten in the way of your safety or wellbeing? How? What kinds of treatment or interventions have most upset you?
- Have you receive a diagnosis for your problems? What do you understand this to mean?
- What do you think of this diagnosis? Do you have a different way of making sense of your problems or symptoms?
- Have you ever thought that the diagnosis/diagnoses you have received may be something to do with the past or current stress in your life?
- What treatments for your mental health/substance use have you received and did they help you? How? If not, why not?
- What current treatment are you having? Is this helpful? How could it be more helpful?

Physical, Mental, Emotional and Spiritual Health
- How do you keep healthy or in balance at times of stress or crisis?
- Do you sometimes struggle to take care of yourself well? What helps you to look after yourself? What makes it more difficult? Do you need support with this?
- What makes you happy?
- What activities make your body feel good, give you energy or help you to feel good in general?
- What physical symptoms do you get when you become stressed or out of balance? How do you manage these? Would you like some extra help with these?
- Do you have beliefs that keep you going during the bad times? How do these help?
- Do you follow any spiritual or religious teachings? What difference do these make to your life? Do they help you make sense of life or give it meaning?

Past Life, Survival and Supports
- What has happened to you in your life that has had an impact on your emotional health?
- Does the past still get in the way of your life or wellbeing now? If so, how?
- What helps you to cope?
- What people or things have supported you in your journey?
- How have you survived until now? What has helped?
- What strengths and personal resources do you have? When are you most able to draw on these?
- How do these help you to manage your life and life challenges?
- What extra supports would you really like in your life?

Working Together
- How would you like me to work with you?
- What would you like me to be aware of in supporting you (from your past or from what you know works well or doesn't work)?
- Is there anything you would like us to change in the way we work together?

Family History of Mental Health Problems[2]
- Has anyone in your family received a mental health diagnosis?
- How was this perceived by the person who received the diagnosis? By the rest of the family?
- What view does your family have of mental health? What do they think of psychiatric medications?
- If you grew up with a parent who was diagnosed with a mental illness, what was this like for you?

Family History of Substance Use Problems
- Has anyone in your family had a substance use problem?
- How was this handled by the person concerned? By the rest of the family?
- What view does your family have of substance use? Of treatment for substance use?
- If you grew up with a parent who had a substance use problems, what was this like for you?

Impact of Mental Health and/or Substance Use
- How does your mental health/substance use problem affect your life?
- What does mental wellbeing mean to you?
- How does your violent relationship affect your mental health/ substance use problems?
- Does your partner use your mental health need or substance use to harm or try to control you in any way? You may wish to give examples and see if any of these are going on for a woman...

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2   In asking questions about family history try to draw out the variety of experiences and values in a women's family of origin as well as extended family. Usually there are multiple stories and perspectives which can support identifying both family resources and limiting beliefs. Using a genogram may be a helpful way to visually record the multiple perspectives that exist within the family.

- Controlling medication/ supply of substance? Forcing you to use with him? Stopping you attending services/groups/appointments? Attending appointments with you and speaking for you? Undermining your confidence and self-esteem, recovery efforts? Threatening to report you to child protection services, police, immigration? Threats to tell friends or family or strangers about your mental health diagnosis or substance use? How do you cope with this?
- Does your mental health/substance use problem affect your safety in any way? How? How do you try to keep safe? What support could help you with this?
- Have you thought about creating a crisis plan/advance agreement/Ulysses Agreement for times when you are in crisis? Would you like more information on this and on how to create one?
- Does your mental health/substance use problem mean that we should make some changes in how we work together? Is there enough time to talk through the things you want to discuss, for example? Do you need to take more breaks to be able to concentrate?
- Are there any changes you would like to make in your substance use? Do you have ideas about how you can make these changes? How confident are you in making these changes? What do you think would help?
- Would you like to receive additional support for your mental health or substance use? What kind of help would you most like? Do you have any concerns about using a specialist service? Is there anything I can do?

Hopes, Dreams and Goals
- What hopes and dreams do you have for your life now? How about in the future?
- Do you have any goals or dreams you want to work on at the moment? What do you need to meet your goals or dreams? Would you like some information? How can I help with this?

Parenting and Caring
- How are things with the children at the moment? Do you have any concerns about them?
- What supports you in your mothering?
- Is there anything you need to help you with your parenting? Is there anything I can help with?
- Have you got a plan in place for the children if you are in crisis? Would you like to create a plan for this? Can I help?

Note: For women who do not have custody or full time care of their children, their children or mothering may still be a concern or a topic they would like to discuss with you. Or it may not be–it may be too painful or raw. Your individual work with a woman should identify what questions concerning children are appropriate to include in this section. If you are not sure, try an open question that asks sensitively whether she would like to talk about her children.

Remember, women are the majority of primary care givers for other dependent relatives (this may include their abusive partner or family members of the abusive partner). This can be a cause of stress and can place multiple demands on a woman. You might like to ask: Do you care for anyone else? Are you managing this OK? What help could you use with this?

1.4.4 Responding To Women: Sharing Power And Responsibility

Attending to the Connections
- **Takeinto account the causes and contexts** of women's mental health/substance use, including their traumatic histories. This means asking about the connections in her life, as she sees them. You can use some of the questions outlined in the piece above.

- **Helpher to make connections** between structural and social inequalities like poverty, unemployment, demands of childrearing, and her mental health problems.
- **Don't make assumptions** about how issues or challenges are interconnected for her.
- **Provide information** on the impact of trauma (and other life experiences such as problems with attachment, neglect, living with a parent with substance use or mental health problems) on substance use and mental health issues[3]. Consider giving written information that can be taken away and read, if this is appropriate to the woman. Always ask permission before giving any information or possible explanations.
- **Take a positive attitude** no matter what unusual mental states the woman is experiencing or has experienced or what substance use has gone on in her life. If you are shocked or taken aback by anything a woman tells you, try not to show this to her in your responses: she needs acceptance, whatever has been going on for her.
- **Watch your language**–find out from the woman how she wants her problems or challenges to be described. Avoid medicalizing her problems or using labels. Questions like Mental health means different things to different people – what does it mean to you? can be helpful for opening up these kinds of discussions.

> I notice the impact of language all the time now. There is a consciousness raising that happens. I think people rally around a new way of describing and thinking about themselves. At the same time, I can see them wilt when they are described in the same old words (Chris, a worker, in Harris and Fallot 2001).

- **Helplessen her self–blame** for the violence and abuse, other trauma and her associated mental health or substance use problems. This can be done by using statements like: It is very common for women experiencing violence in their lives to... You are not alone in having these feelings/experiences... You are not to blame for the violence in your life or for trying to cope with it the best way you can.
- **Recognize and respond to her distress signals** – this may mean asking questions like: What are the warning signs that you are moving towards an emotional or mental crisis? What would you like me to do if or when this happens when we are working together?
- If you have to **report to other agencies** (e.g. child protection, mental health) make sure she knows that you are doing this and why. Involve her in making the call if possible. Tell her at the start of your work together the limits to confidentiality and what will happen if you need to break confidentiality. Give her reminders occasionally of the boundaries to your confidentiality (please see Empowering Strategies When Children Are At Risk section and *Records Management Guidelines: Protecting Privacy for Survivors of Violence,* available at www.endingviolence.org).

Supporting Self–Efficacy
- **Honour where a woman is at,** her survival and coping, no matter how self-damaging some of a woman's behaviour has been. Remember all behaviour has meaning and can be viewed as adaptive coping strategies.
  - Offer affirmation and validation for how a woman has survived
  - Validate her courage, persistence, energy and power whenever you can
  - Acknowledge all her moves towards safety, however small and tentative
  - Emphasize hope and recovery in all your conversations with her.

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3   CAMH has some great booklets that do this. One of their factsheets is in Appendix 2 for an example of what is available. See http://www.camh. net/Publications/CAMH_Publications/women_signs_common.html.

- **Assume she is the expert on her life** and on the abuser's behaviour, no matter what difficulties she has had or still has in terms of being in touch with reality, using substances or engaging in risky behaviours that put herself in danger. Recognize when she is not exercising/able to exercise her expertise on her life and support her to do the best she can.

Addressing Safety—Both Internal and External

- Work with her to **maximize psychological and internal safety** as well as physical and external safety. Help her to identify, recognize and manage her warning signs, cues and triggers for using substances, mental health crisis, trauma memories, dissociation etc. Help her to develop new and effective coping and healing strategies when she is ready. Respond appropriately and sensitively to self-harming behaviours and learn from her what she needs at these times. Do not ask a woman to give up indirect ways of expressing her pain and anger (like self-harm) until she has found new ways to do this that work for her. Comment on your concerns for her safety and her risks to self without judging or trying to take control. Collaborate in problem solving, safety assessment and safety planning. There are many helpful strategies to inform this work in the sections Safety Planning with Women with Mental Health Problems and Safety Planning with Women Using Substances.

Supporting the Development of Safe Relationships and Connections

- **Provide information** and enable **access to appropriate support groups** or networks and self-help groups. Talking with other women in similar situations or with similar past experiences is often very helpful, particularly integrated support groups that help women to recognize the interconnectedness of violence and substance use or violence and mental health or all three.

If there are no such groups in your area, what could be done to start one up? Are there allies in other agencies that would be supportive or offer help? Are there other workers in your own agency who have an interest in running groups or creating more integrated supports for women? Are there support/self help groups already running that may be interested in helping you to develop an integrated group as part of their programs? Are there recovering women/consumers/survivors who would be interested in helping you to run a group like this? Are there funding streams in your local area that could be tapped into?

Support Women Who Are Mothering

- **For women who are mothering, appreciate its importance in her life,** whether she has her children with her or not, and in spite of whatever is going on for her in her life around mental health or substance use challenges. Find out about local mental health and/or substance use treatment/harm reduction services that are flexible and accessible to mothers—develop relationships with these services. Ask a woman how you can best support her in her mothering (again, whether she has custody/full time care of her children or not). For example, she may want you to support her to be visited by her children when in hospital or treatment.

Conclusion

"And it feels at the beginning that it's the end of the world, but it's actually the beginning of a new life" (Bland 2001).

Our work with women can be tremendously powerful and positive if we use the values, principles and approaches described above in our day-to-day interactions and relationships. Feel free to add to the lists of questions and responses and develop a more personalized approach that suits you, your service and the women you work with. Ask for feedback from the women you work with on a regular and informal basis. Don't be afraid of feedback! It is one of the best ways to improve our work with women survivors. While this section emphasizes asking a woman what she wants and needs, sometimes women will not know what they want and need and in these situations we will need to provide some gentle and compassionate direction. Finally, remember that the implementation of a few basic improvements can significantly help to overcome a woman's sense of powerlessness. For example, having a trusted confidante, feeling safe and having choices are huge developments for many women.

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1.5 Moving Towards Safety: Using A Harm Reduction Framework

By Tessa Parkes

1.5.1 Introduction: What Is Harm Reduction?

One of the main goals when working with a woman who uses substances is supporting her to reduce harms related directly and indirectly to her substance use. A harm reduction approach acknowledges that most people struggle to make changes in their lives even when faced with extremely negative consequences for their safety, health and wellbeing. It focuses on harms rather than the substance use itself, enabling much wider windows of opportunity to be created for those who use substances and their supporters. It comes from the premise that small changes in use can reap big rewards in terms of the impact on a person's life.

The feminist principle of meeting a woman where she is at is central to the harm reduction approach. We acknowledge the complexity of women's lives while also being pragmatic and practical. Harm reduction allows service providers to work with women along a continuum of substance use, not just helping those who are able to abstain. It encourages creativity and the individualization of support, with the woman at the centre of her care.

Harm Reduction Principles

- Pragmatism
- Human rights
- Focus on harms, not only the substance
- Provide a variety of options, doors and support
- Priority of immediate goals and working towards safety
- Involvement of women who use substances (British Columbia 2005)

> A harm reduction approach acknowledges that most people struggle to make changes in their lives

1.5.2 Substance Use As A Continuum: Using A Harm Reduction Framework

The harm reduction approach views substance use as a continuum rather than in a dualistic way as beneficial or out of control (see text box below).

Continuum Of Alcohol And Other Drug Use

Social/Recreational Use–Some of us use alcohol and other drugs in small amounts without major problems.

Situational and Intensive Use–We may use substances to cope with the demands of a certain situation. Or we may experience harm through consuming a large amount of drugs over a short period of time, or by engaging in continuous use over a number of days or weeks.

Problem Use–Problem use creates negative consequences in one or more areas of our lives.

Dependence involves:
- Excessive use in spite of harmful consequences and regular and serious problems
- Increasing focus on use
- Loss of control over how drug is used
- Experience of withdrawal symptoms when use is stopped (Poole and Members of the virtual community 2007a).

There are many explanations for the development of dependence or addiction. It is often helpful for women to see dependence as a cycle that begins with using substances as a way of coping with difficult experiences and feelings. While the substance may initially facilitate coping, over time it takes away individual power, choices, and abilities, as is shown in the diagram (Health Canada 1994: this has been placed in handout form in Appendix 1 for use in discussions with women about their substance use).

Difficulty Managing Experience, Emotions — May Start Here — Use of Alcohol or Other Drugs — Short Term Effects — Increase Time Using Drug — Decrease Time Using Other Skills — Skills Erode
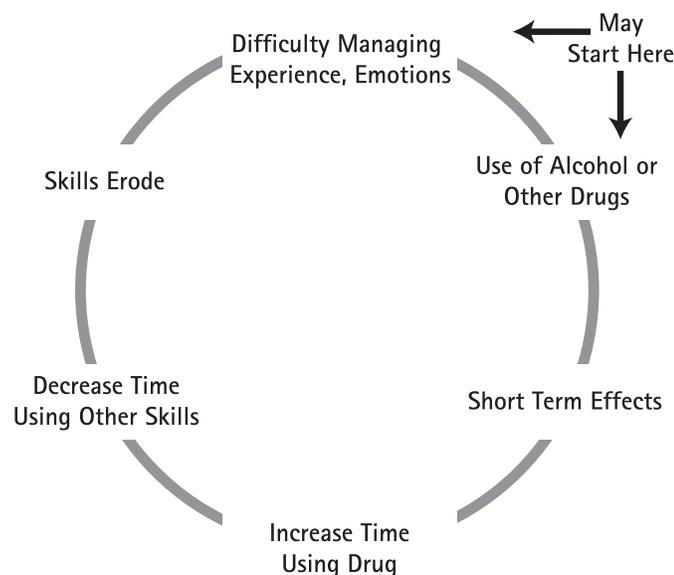
This understanding of cycles of dependence helps us to work constructively with a woman to talk about where she is on the continuum with different substances, make realistic plans for reducing risks, and make connections for changes in other life areas (Poole and Members of the virtual community 2007a). This work can help to reduce the shame and guilt associated with use and support her in her readiness to make changes in her life. Support is guided by the priorities set by the woman herself, which may include overall health and safety issues such as making changes in housing and relationships as well as substance specific concerns.

One of the most significant aspects of the continuum approach is recognizing that people can change their use of substances at any point, not only when they "hit bottom" (when use is causing significant problems). Even brief support can be helpful to a person at any point on the continuum of substance use (Miller 2006). It is important that services are provided in a non-judgmental way and that safety is created for women to be able to discuss the benefits of substance use, or the "positive intentions" (Kasl 1992) behind their use (to relax and calm me down, to help me deal with my anger, to help me forget), as well as the drawbacks or negative aspects of their use. Providing effective brief support on substance use issues in the context of anti-violence services can also help prevent the (further) development of substance use problems for women (Poole and Members of the virtual community 2007a).

Research also indicates that the relationship with the service provider and strengths that women bring to the counselling relationship are strong predictors of outcome. Collaborative support with women that draws on present-focused, appreciative and motivational interviewing/counselling[1] approaches can all be helpful. These approaches are pragmatic and strength (not problem) focused (Miller and Rollnick 2002)[2].

Service providers are increasingly acknowledging that there is no one way to change one's patterns of problem substance use, or one treatment that is appropriate for everyone—there are many roads to change or recovery.

The treatment world is changing to offer new and shorter forms of treatment groups such as support for withdrawal management on an outpatient basis (daytox) and short-term (e.g. two-week) groups that help women discover new ways of managing their substance use and other problems.

One of the most significant aspects
of the continuum approach is recognizing
that people can change their use of
substances at any point

1   Motivational interviewing is a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counselling, it is more focused and goal-directed. See *http://www.motivationalinterview.org/clinical/whatismi.html.*

2   Some warn that women in abusive relationships may not be able to act independently, so motivational approaches should therefore be used with caution.

> **Good Practice Example:**
>
> An initiative that demonstrates a collaborative and empowering approach to helping women to make changes in their lives, including changes in substance use, is the *Honouring Ourselves and Healing Our Pasts* manual (Salmon and McDiarmid 2005). This was a resource created to support Aboriginal mothers in the Downtown Eastside of Vancouver who wanted to make changes in their substance use. The approach involves a woman creating a Wellness Plan with the help of a support person, based on the teachings of the Medicine Circle/Wheel. Medicine Circle/Wheel teachings include recognition that individual and community wellness have four inter-related aspects: physical, mental, emotional and spiritual wellness. The approach is built upon relationships of trust and respect between an Aboriginal woman and her support person. (This resource was developed by Downtown Eastside Healthy Communities, Mothers and Children Community Leaders Working Group, with the support of the Aboriginal Mothers Advisory Council and Local Advisory Committee).

1.5.3 The Stages Of Change Model

"What can we do to support someone where they are? How can we leave paths open, build bridges?" (Alaska Network on Domestic Violence and Sexual Assault 2005)

The stages of change model (Prochaska and DiClemente 1984) is a useful approach to help service providers understand the change process and match interventions with a woman's readiness to change. Many of the principles of harm reduction are reflected in this model, including starting where the woman is at and working with her to prioritize her goals[3]. This model suggests that change is a process, not an event, and in order for individuals to move forward in their behaviour change certain tasks need to be completed, such as recognizing there is a concern and working through ambivalence. The stages are:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

In order to provide effective and supportive care for women it is important that the intervention matches the stage of change. Women may be at different stages of change or readiness depending on the substance or behaviour they have identified.

The following table by Urquhart and Poole (2007) offers suggestions for interventions at each stage of change.

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3 Some would argue that a drawback of this model is that it assumes that change is within the individual's ability and lacks an analysis of the role an abusive partner plays in ensuring a woman's continued substance use.

STAGE	READINESS FOR CHANGE	ROLE OF PROVIDER AND STRATEGIES FOR INTERVENTION

PRECONTEMPLATION	May or may not be aware of reasons for change
	
	May not be ready, able or interested
		• Provide information and raise doubt – increase the woman's perception of the risks and problems with current behaviour
		• Emphasize personal choice and control
		• Be empathic and offer hope for change
		
		Strategies:
		General Information Exchange
		  – **Find out what she knows about the subject:** "What have you heard about how cocaine impacts your mood/helps you deal with traumatic memories/helps you cope with the violence in your life?"
		  – **Important to ask permission:** "Would you like to know more about the effect of … on ….?"
		  – **Use general statements such as:** "Generally women feel…" or "What happens to most women…"
		  – **Finish with inquiring about how the woman understands the information:** "What do you make of this?"
		  – **Gathering Information:** Tell me about a typical day. Where does your use of alcohol fit in?

CONTEMPLATION	Considering change	• **Tip the balance:** evoke reasons to change, risks of not changing; strengthen the woman's self efficacy for change
		• Review past successes and look for exceptions
		
		Strategies:
		  – **Assess importance:** How important is it to you to (change)? If 0 was 'not important' and 10 was 'very important', what number would you give yourself?
		  – **Assess confidence:** If you decided right now to (change) how confident do you feel about succeeding with this? If 0 was 'not confident' and 10 was 'very confident', what number would you give yourself?
		  – What are some of the good / not so good things about your use of _____?

PREPARATION	Ready to plan change	• Help determine the best course of action to take in seeking change
		• Help to reduce barriers, set realistic goals and build on coping skills
		
		Strategies:
		  – What kind of support do you need to be successful in reaching your goal?
		  – What are you doing already to help you make changes?

ACTION	Change is happening	**Support efforts**
		• Anticipate and normalize relapse
		• Discuss relapse prevention strategies and problem-solving skills
		• Monitoring: evaluate and modify as needed
		
		Strategies:
		  – What are some of the things you have done in the past to help you cope?
		  – How do you plan to manage (high risk situation)?

MAINTENANCE	Change has occurred	• Show support and reinforce the positive changes made
		• Normalize the fact that some days will be better than others
		• Help strategize how to handle relapses or slips
		• Continue to check in on how she is managing and offer support
		
		Strategies:
		  – What do you think you need to do to sustain the positive changes you have made?
		  – **Keep the door open:** "You have made incredible changes, and some days will be better than others. I want you to know that my door is always open."

When working with a woman to identify her own goals for change you can consider together:

- What kind of changes does she want to make?
- What timeframe does she want to achieve these changes in?
- Does she have the tools to cope with these changes?
- Are the changes achievable?
- What support does she need to make these changes?
- What resources or services does she need to make these changes?
- What are the barriers to making these changes?

In essence the approach could be described as "walking with" women, rather than telling them what they should be doing.

If a woman wants to make changes to her substance use, an advocacy-based counselling approach may be helpful, including:

- Repeating information
- Providing structure
- Simplifying goals
- Advocating for her inclusion in shelters and other service programs
- Understanding the impact of substances on safety planning (Alaska Network on Domestic Violence and Sexual Assault 2005)

One of the key aspects of this approach is to build self-efficacy, which is so relevant to a woman's confidence in being able to make changes in her life. Obviously, for women with trauma, mental health and/or substance use problems, their self-efficacy may be severely limited by external and internal factors. Safe, trusted, supportive and empowering relationships and experiences can help to build self-efficacy and confidence: anything you can do to provide a woman with these supports will be positive in enabling her work towards change.

If the woman shares with you that she is continuing to use drugs or alcohol, the most important thing you can do as her support person is not to give up on her. Remind her that you are here for her, and will support her unconditionally (Salmon and McDiarmid 2005).

1.5.4 Working Towards Safety

We do not need to be experts in drug and alcohol work to make a difference in this area with women: we just need to be willing to see substance use as part of many women's lives and therefore part of what we are there to help them with, should they want us to.

A study by Greaves et al (2006) shows the benefits of providing support to women who experience violence and have substance use problems. This study explored the changes in use of alcohol and other substances by women when they moved into transition houses and then again three months later. The study found significant reductions in women's use of alcohol and stimulants across this time period (no reduction in use of depressants or tobacco) and levels of stress decreased. Changes in substance use were related to a number of factors such as financial concerns, mothering, relationships, levels of social support, and physical and mental health issues.

The study found that the assistance provided by the shelters played a pivotal role in helping women restructure their lives, including making changes in their use of substances. Some shelters used brief interventions, and some had more intensive approaches to helping women, but it is of note that women's substance use decreased irrespective of the level of intervention provided by the shelter. The researchers concluded that both brief and more substantive interventions could assist women in reflecting on and making changes to their substance use. Broader support (e.g. in finding housing, accessing income assistance) also contributed to helping women reduce or stop their substance use.

What the study indicates to the anti-violence sector is how positive our interventions with women around their substance use can be, no matter how brief our involvement is. If we help women make the connections between their substance use and the violence they have experienced in their lives, are supportive and non-judgmental, provide relevant information and referrals, then we are actually doing the kind of intervention that is desperately needed by women to help them make changes.

1.5.5 Practical Suggestions For Harm Reduction

Here are a number of practical suggestions for working with women on their substance use from a harm reduction perspective:

Asking the questions
- Ask the questions about a woman's substance use in sensitive and non-judgmental ways and if she does not want to talk about her substance use, explore other ways to reduce harm and increase her safety.
- Frame substance use as a way of coping, to lessen the stigma attached to disclosing
- Find out if the woman is motivated to change any aspects of her substance use and her reasons for wanting to change.
- Find out what the woman wants to address first of all and how she wants to address it–it may or may not be substance specific.

Help her make the connections
- Normalize her experience and reactions.
- Help her to recognize the root causes of substance use in her life in a careful and sensitive way.
- Ask about what the substance offers her.
- Ask whether and how substances have contributed to her safety in her relationship and what role her abusive partner plays in her use of substances, including whether he would be supportive of changes in her use.
- Discuss the ways in which substances are affecting all areas of her life (health, family, supports, work etc.).
- Help her to recognize her triggers for substance use and, if she can, how to avoid or cope with them.
- Times of stress and transition are often times when women's substance use increases so these can be times for a woman to take stock of her substance use, to assess what it is currently giving her and what is taking away.
- Develop a safety plan for the woman and her children specifically for when she is using or planning to use (is there someone who can take care of the children?). See section Working on Safety with Aboriginal Women on Reserve.

> **"I** could not recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa" (Woman survivor quoted in Alaska Network on Domestic Violence and Sexual Assault 2005).

Provide information

- Find out what information a woman already has on alcohol and drug use and find out what else she would like to know—you can then work on filling the gaps with her permission and appropriate to her literacy level.
- Look for opportunities to provide information on the effects of drugs and alcohol on health and wellbeing, how to use drugs or alcohol more safely, decrease risk and increase health and wellbeing in other ways (See resources at the end of this section for some sources).
- Offer information and perspectives that may encourage future change (i.e. outlining options for treatment or harm reduction)—ensure all the information you provide is factual, current and clear.
- Offer as many options and possibilities as possible.
- Ask permission before giving any information—this is respectful and makes the information easier to accept because it is seen as optional rather than recommended.
- Respond honestly and thoughtfully to any questions.

Be Creative – Think about creating a binder full of current information on alcohol and drugs (from a harm reduction perspective) and other related topics such as pregnancy, child development and parenting, FASD, recovery and healing, to share with the women you are working with. Invite women to look through the binder on their own and take copies of the handouts they like. In the Honouring Ourselves and Healing Our Pasts (2005) manual, Aboriginal mothers suggested the following information be included in such a binder:

- Information about the short and long term harmful effects of alcohol and drug exposure for fetal development, infants, older children and adults
- Common myths and misconceptions about substance use and pregnancy
- Indicators of high risk drinking and drug use, including issues related to metabolism of drugs and alcohol in women, lifestyle, food intake, nutrition, exercise and sleeping patterns
- Information about drinking, drug use and breastfeeding
- Information on the effects of methadone on fetal development
- Information on the effects of prescription and over-the-counter medication on babies and children
- Information on tobacco and fetal development and children
- Information on healthy infant and child development
- Information on healthy alternatives to drinks containing alcohol and caffeine
- Information on basic life skills such as budgeting
- Stories from other women who have been through the healing and recovery process

- Contact information for other useful services and resources
- Information on how to cope with difficult memories from childhood and on coping with grief and loss of childhood, abandonment, or how you were parented
- Skills for building friendships
- Ideas to cope with stress and to develop a positive outlook on life
- Other information resources for the binder could be
- Phone numbers for information hotlines
- Ways to access libraries and electronic libraries for information
- Provincial or federal support organizations like the Women's Addiction Foundation.

Building readiness to change

- Do not assume the woman is ready to make changes in her substance use and don't assume she is not.
- Work with a woman to think about alternatives to substance use that may work for her and other ways to address the positive intentions or benefits she has identified regarding her substance use.
- Explore the pros and cons for making the changes–acknowledge the role of ambivalence.
- Explore a woman's confidence in being able to make the changes and try to build her confidence wherever possible.
- Focus on the harms, not the substance use itself.
- View your role as a person who may help to plant seeds of hope and change that may grow and flower later.
- Help a woman to develop other hobbies and interests.
- Help a woman to develop or re-establish additional life supports.
- Realize that alternative methods of coping often need to be found before a woman is able and willing to let go of the substance use.

Try to keep your work together as positive as possible: changes to substance use do not usually happen overnight. Focus on what the woman is accomplishing now and the important steps she has already taken towards her healing and recovery (Salmon and McDiarmid, 2005).

Supporting change

- Explore ways to decrease the amount of alcohol or drugs used at a time or to decrease the number of days in a week or month that a woman drinks or uses or look at changing the times, locations or situations of drinking or using.
- Acknowledge that change in, or recovery from, substance use is different for everyone-there is no one way to change patterns of problem substance use, or one "treatment" that is appropriate for everyone.
- Understand that even if a woman needs to take a break from using substances due to the negative effect on health and other life problems, it may not mean needing to be abstinent for the rest of her life.
- Realize that relapses are common and should be viewed as opportunities for learning rather than failures.
- Understand that lessons learned when making positive changes in one area of life may be helpful when applied to other life areas.
- Provide information about self-help and support groups or networks. For example, the 12-step approach taken by AA and other abstinence focused organizations may not be helpful for all women and has been experienced as disempowering by some. Alternative models such as Charlotte Kasl's (1992) 16-step model can be discussed.

Conclusion

"Survivors say again and again that they want staff to be human—not experts, nor messiahs or gurus, but fallible, compassionate, ethical, informed and hard-working professionals who can bear witness to their experiences and travel at least part of the way with them on a healing journey" (Saakvitne et al 2002).

Taking a harm reduction approach to working with women with substance use concerns is not easy. It is certainly not about indifference or about ignoring or avoiding engaging with the substance use and its place in a woman's life. Working from a harm reduction approach relies heavily on our ability to support women creatively, compassionately and confidently while sometimes feeling fearful of the consequences of a woman's behaviour on her health and wellbeing. We need to recognize the complex relationship between violence and substance use, ensuring that women receive support that places safety first. The key is to be available to a woman in helping her with her substance use in the way that she most needs, to walk alongside her and not to give up on her.

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.
There is a good deal of information available online about women and alcohol, tobacco, prescription drugs, and illegal drugs. For reliable information on the short- and longer-term use of these drugs see the "Effects Series" on the website of the *Alberta Alcohol and Drug Abuse Commission (AADAC): http://www.aadac.com/547.asp.*

The *Our Bodies, Ourselves* website offers information on drugs most commonly used by girls and women—alcohol, tobacco and other mood altering drugs such as ecstacy—as well as good information on other aspects of women's health. *http://www.ourbodiesourselves.org/book.*

There are also many online resources available on pregnancy and substance use. The *AADAC Effects Series* and a booklet available from the Centre for Addiction and Mental Health in Ontario entitled *"Is It Safe for My Baby?"* provide excellent information for women on the risks of substance use in pregnancy Available online: *http://`.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/Safe_Baby/index.html.*

Also see the resources at *www.addictionpregnancy.ca/home.html.*

1.6 Taking Care of Ourselves: The Impact of Working within Systems

BY MAGGIE ZIEGLER

Advocacy, support and counselling for survivors of violence are delivered within challenging social, political and economic systems. The reduction or elimination of services, accompanied by increases in poverty and homelessness, increases pressure on our services. Lack of resources and referrals, financial constraints and intersecting oppressions affect the women we work with and ourselves. There is a constant struggle to do more with less.

The term "vicarious traumatization" was coined in 1990 by Lisa McCann and Laurie Pearlman to describe how our exposure to trauma survivors and their stories changes us. There are a number of factors contributing to vicarious traumatization (VT), and one of them is the environment in which we work. This has as powerful an impact as the other causes (our exposure to survivors and their stories, the nature of our work and workplace, and our own experiences and histories). In fact, many people involved in anti-violence work now speak of their reactions to the unsupportive and deteriorating systems in which they work as more difficult than their contact with survivors. In order to address the systemic aspect of VT we need to understand the situation, identify our response, examine how systemic VT affects us and our work, and find both individual and organizational ways to address this problem.

1.6.1 The Social/Cultural/Political Context

- What are the systemic obstacles to my work?
- How does the community respond to the work my organization and I are doing?
- How does the community view the population I serve? How does media, etc. view the issue of violence against women?
- What are other social/political factors influencing my ability to do my work?

Making a list of your answers to these questions identifies and honours the difficult environment in which you work. Some items may be familiar, some new, but together they offer a validating of your experience. Taking the time to name and reflect on the breadth of the systemic challenges that you face every day is important. You and your co-workers could make separate lists and then compare them.

1.6.2 Our Response To The Context Of Our Work

- How do the systemic obstacles and community responses that I have identified affect me?
  - What feelings do they bring up in me?
  - How do they affect the way I think about myself and the women I work with? Have they affected the way I make meaning of the world?
  - What happens in my body when I contemplate these obstacles? Do I have problems sleeping, anxiety, depression, etc?
- Which are the most troublesome or problematic of these responses for me? Why?

Our responses are varied and there is no right answer. Whatever you feel, think and experience in your body is what you need to pay attention to. Laurie Pearlman and Karen Saakvitne do suggest, "Perhaps the most insidious impact of vicarious traumatization is its assault on our hope and idealism." This assault on hope is perhaps strongest in the systemic aspect (i.e. systemic barriers to change and their accompanying impacts and challenges) of vicarious trauma.

1.6.3 How Systemic Vicarious Trauma Affects My Work

- Am I cynical and discouraged about the system's ability to support survivors? Does this affect how I talk with survivors?
- Do I engage in conversations with co-workers about the obstacles to women's safety and health that leave me feeling more discouraged?
- Do I go through the motions of advocacy or referral without much hope? What does this communicate to the survivor?

We need to consider that our own systemic vicarious trauma can affect the women we work with. If VT is the *accumulated* impact of working with survivors, then systemic VT is the *accumulated* impact of being unable to assist women with the resources and referrals that they need. Addressing the impact on ourselves avoids infecting others with our anger, despair and frustration. When we feel weighed down, women sense our powerlessness and feel increasingly helpless themselves. Taking care of yourself helps everyone.

1.6.4 What I Can Do To Take Care Of Myself

First, identify and acknowledge the causes and impact of systemic VT
- What kind of self-care activities can help you in daily management of VT?
- What kind of activities can give you time-outs, or opportunities to just escape?
- What would help transform your systemic VT?

Pearlman and Saakvitne offer an ABC model to address VT: bringing into our lives Awareness (attunement to our needs, limits, emotions and resources), Balance (inner balancing of the multiple aspects of ourselves and outer balance of activities) and Connection (to oneself, to others and to something larger). Consider an ABC plan both for work and for your private life.

Transformation requires shifting the VT related loss of hope and meaning. False hope or naïve optimism isn't useful, but finding ways of being and thinking that bring a quality of equanimity and restore a sense of possibility are essential. This might come from time in nature, deepening connections with others, spiritual practice and/or activism.

1.6.5 How My Workplace/Agency Can Address Systemic Vicarious Traumatization

- Acknowledge systemic VT as significant
- Identify ways in which talk about systemic obstacles increases discouragement, and find ways of talking about systemic VT that are meaningful and supportive
- Agree on collective actions that can be empowering group responses to systemic obstacles

It is critical to find collective and empowering responses that avoid the shared complaining that can entrench our VT. Establishing specific time-limited procedures is helpful. Perhaps allowing ten minutes at a staff meeting or peer consultation session for venting could release energy. Or maybe you just need a few minutes to talk

about your responses to systemic obstacles, silently witnessed by colleagues or friends. Their attentiveness deepens connection and avoids tag team dynamics of depressing stories. And involvement in collective activities to address societal imbalances is the best antidote of all.

1.6.6 References, Resources And Further Reading

This section is based on the work of Laurie Pearlman and Karen Saakvitne:

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Saakvitne, L and L Pearlman. 1996. *Transforming the pain: A workbook on vicarious traumatization.* New York: W.W. Norton.

2.1 Survivor's and Service Provider's Stories

A Survivor's Story

I was raised in an abusive, alcoholic home and learned feelings of anxiety and fear early in my life. Love and affection were given only for agreeable and proper behaviour. I married at 17 in order to escape my home. My husband reinforced my insecurity and poor self-esteem on a daily basis. He left numerous times for other women, and told me I needed to try harder to please him and keep him happy. My first bout of extreme depression began; I was put on antidepressants without any actual treatment and felt nothing for several years, including joy at the birth of my daughter. I divorced and married a man 20 years older than me who had a drinking problem. I married my third husband knowing he was abusive and drank too much, but he was put on medication and that seemed to help him. As time went on his drinking increased to half to a full bottle of whiskey every night. His abuse increased with his alcohol consumption. This included verbal and physical assaults. Any social life we had came to halt and my energy slowly dissipated until I was just sleeping and then getting up to go to work at my afternoon shift job as a care aide. I started finding work almost impossible and had a few breakdowns at work as well as missing work so I could sleep all day. I could not have told you that I was depressed, as I did not have a name for how I felt. I also could not tell anyone what was going on at home as then they would know I was a complete failure. My family doctor recognized my anxiety and prescribed Paxil and Celexa, but I could not share the abuse I was experiencing with her.

I decided to end my life, as I could not bear the pain anymore. I went to a clinic to renew my prescription for Celexa with the intention of overdosing. My main concern was my daughter and so decided to crash my car so she would think it was an accident instead of on purpose. The doctor at the clinic was very observant and asked me outright if I was contemplating suicide, and I was so taken aback I said yes. She put in me touch with mental health immediately and within a few days I was seeing a psychiatrist. She was kind and observant and seemed to understand what I was experiencing and for the first time I started to feel safe enough to share my feelings and tell the truth about how I was feeling. It took time before I could tell her about the abuse, as I was so ashamed. With new medication and her giving what I was feeling a name (posttraumatic stress disorder, severe depression, anxiety and a total lack of self-esteem) I somehow started to feel that there was some hope. As our visits progressed, she felt that the day program would be of help and she arranged for me to start. The first month was so hard, as my energy was nonexistent and getting out of bed a major feat. I missed a lot of information at first, as my focus and memory were impaired. I often felt annoyed at the counsellors as they kept saying I had to get there daily and on time. I did not feel that they understood how difficult that was for me. I suffered horrible anxiety at the thought of being in a group and being expected to talk about my life. As time went on, I started to see the benefit of the group and struggled to grasp the ideas they were teaching. I did not tell the group of the abuse at home as the shame and humiliation were mine only. I started to gain some confidence and after an abusive episode I told my husband that if he ever touched me again, I would leave him.

My husband once again verbally and physically assaulted me and forced me out of our home, locking me out. I had only a nightgown on, and he refused to let me have any clothes or shoes. I phoned the police, and they

assisted me in getting my personal items and arranged for me to stay in a safe house. My frustration increased when my husband told the police that I had a drinking problem and mental illness, was on medication and had gone ballistic because he forgot to take out the garbage. The worst thing for me was that I could tell by the difference in the way the police spoke to me that they believed him. My humiliation was complete and my shame and embarrassment were devastating. I remained at the safe house for a while, then went to stay in the basement of my daughter's house and tried to figure out what to do.

It was at this point that I shared about the abuse in my marriage with the day program group. The counsellors, while skilled, could not really help me with the issues regarding abuse nor did they refer me anywhere to deal with them. They said I did the right thing leaving but were no help in identifying the pain, loss, shame and hurt I was feeling. One night I phoned a counselling program for abused women after seeing an ad in the paper and, crying, told them the trouble I was experiencing.

From the first meeting with them, I felt a hope that I had not felt before. In the one-on-one sessions I found people who could understand what I was feeling. In the group meetings I met other women, young and old, attractive, intelligent and caring who expressed the same things that I was feeling. I cried, suffered, talked and listened as others did the same and finally started to understand that just as we women shared a lot of the same experiences, the men also shared all the same traits of anger and oppression. I started to understand the cycles of abuse and my part in tolerating it. I learned that women in abusive relationships often suffer from depression and seek ways to medicate the pain, with alcohol and drugs prescribed or otherwise. I, for the first time was not alone. It was through the STV Counselling program that I gained the strength to stay away from my husband and proceed with the divorce. Mental Health helped me with many issues related to my illness, but they lacked the knowledge or understanding to really identify and help with the abuse issues.

I am still on the road of recovery, but I find the mental health support groups and STV Counselling program are both needed to address not only some of the same issues, but different ones also. The most helpful thing at the STV Counselling program was the kindness and non-judgmental way they handled my problems and the knowledge they possessed about issues of abuse. Just knowing I could call them if I felt unsafe and that they would help me was so essential to my recovery. The most important thing that mental health offered was knowledge of my illness and the medications that I was taking. I have discovered strengths and abilities that I did not know I possessed; this is a gift from the kind, caring, understanding and skilled people at the STV Counselling program and the people at Mental Health. Between the two I feel like I am becoming a whole person for the first time in my life.

A Service Provider's Story

During our intake process, this woman spoke of a long history of abuse in relationships and mental health issues. She described a childhood marked by parental alcoholism, neglect, verbal, emotional and sexual abuse, and similar experiences in her adult partner relationships. She described episodes throughout her life of severe depression, anxiety and suicidal thoughts and plans. She spoke of being recently diagnosed with posttraumatic stress disorder and of her involvement with the day program at the local mental health unit. As I listened to her recount her story, I was touched by her courage despite many setbacks, her sense of humour and generosity of spirit, as well as her commitment to maintaining health and well-being for herself.

Our agency responded to her needs by placing her on a prioritized waitlist for short-term counselling specifically designed for women referred by a mental health service provider. Within a week she was offered individual counselling services. She was also offered and attended our weekly drop-in support group in conjunction with the one-to-one sessions. The focus of the counselling work in those early days was on creating safety within the counselling relationship and learning and practicing skills and strategies aimed at stabilizing her mental health concerns. Simply put, we talked about safety and self-care. As we continued, we collaborated

on the goals of counselling: to integrate her thoughts and feelings and to explore the relationship between her mental health issues and her experiences of abuse.

As the counselling progressed, she attended more abuse awareness groups and groups that focused on changing life patterns; these closed groups gave her the opportunity to connect with other women over the course of several weeks. These relationships were a significant part of the therapeutic work—helping to allay the feelings of loneliness and isolation so prevalent with mental health and abuse issues. We continued to integrate the lessons learned from the Mental Health program with those of our agency. Although I did not meet with anyone regarding this particular woman, I had attended general program information meetings, which helped me to understand the content and focus of the mental health day program. In retrospect a case consultation in collaboration with the woman would have been beneficial, and this has prompted our agency to consider a regular interagency meeting for both staff and clients. A reciprocal relationship between agencies who deal with abuse issues and those who deal with mental health issues is the ideal. We continue to strive for this. It was a great honour for me to have worked with this woman; she taught me so much about hope, resiliency and kindness.

2.2 Definitions of Main Mental Health Diagnoses and Types of Involvement with Substances

By Tessa Parkes

2.2.1 Introduction: Guidance On Using This Section

Aims Of The Section

This section is designed to provide information on the major mental health/psychiatric diagnoses and problem substance use categories. We believe that building alliances and coalitions with mental health and substance use/addiction service providers requires understanding the language and perspective of these sectors. Being informed about the way that common mental and emotional problems are understood within psychiatric services, and substance use problems are defined by addictions workers, can help you to advocate effectively for the women you work with.

Using The DSM

The diagnoses presented below come from a medical model of understanding mental health problems and are based on certain identified behaviours or "symptoms". The Diagnostic and Statistical Manual (DSM-IV) is most frequently used to inform practitioners who are working within mainstream psychiatric services and this has therefore come to represent the orthodox approach to mental health practice.

Critical Perspectives

There are, however, many different views as to the nature and cause of mental health problems, and on how individuals with these problems should be supported, helped or treated. Many of these views on mental health and mental distress or "illness" are critical of mainstream psychiatric orthodoxy. This tool kit as a whole provides a fair degree of critical analysis of mainstream psychiatry and we have included a number of excellent references and resources should you wish to explore this area in more depth.

Many feminists have argued that common life experiences become medicalized within the psychiatric framework and a person's problems become decontextualized from their life experiences. Feminists have also critiqued the lack of attention paid to the social inequalities that women face and the relevance of these inequalities to mental distress. Social inequalities based on gender, race, age, sexuality, ethnicity, religion and culture, physical ability and others, are largely ignored. The mental and emotional problems people encounter through living lives constrained and challenged by these inequalities are put down to their individual pathology (usually biochemical imbalance and genetic causes). Women's common experiences of childhood and adult violence, trauma and abuse, social and economic inequality, the pressures of caring for others and balancing many demanding social roles, is often ignored as irrelevant to their mental health. A clear example of this can be seen in the DSM, where the impacts of trauma are excluded from all diagnoses except PTSD.

Please keep these critical perspectives in mind when reading this section, to ensure that the diagnostic criteria is not overly relied upon in understanding women's lived experience.

Format Of This Section And Suggestions For Using This Section In Your Work With Women

The format of the section provides brief information geared towards a general public audience and then gives the DSM diagnostic criteria for all the major mental health diagnoses. We offer the DSM definitions so that workers and women can understand the lens/language that has been used in arriving at different diagnoses. It can be helpful to go over the DSM criteria with a woman who has a mental health/psychiatric diagnosis item by item, to see if this fits her experience. (We do not suggest doing this if a woman does not have a diagnosis). For example, workers could use the following questions to guide a woman in understanding her experience of the diagnosis:

- Here are some of the symptoms that lead to the diagnosis you've received...
- What experiences do you recognize for yourself as being significant in your life?
- What are you experiencing that is not listed here?
- How do you think these symptoms are related to what is happening in your life right now?
- How are they related to what has happened in the past?

Definitions And Diagnoses

2.2.2 Depression

Depression can include feelings of hopelessness, worthlessness, sadness, disappointment and emptiness, and mood swings. It is categorized by psychiatry as a mood disorder that affects 1 in 10 Canadians in their lifetime. Depression can involve all areas of life, including physical changes, changes in thinking, changes in feeling and changes in the way we act. Depression can last a long time and be very painful.

Possible symptoms of depression include:
- Loss of interest in doing things that one has found enjoyable in the past
- Pulling away from social, work and play activities—not wanting to be with others
- Having no sense of personal value
- Loss of feelings, so life has no "colour"
- Sense of crushing or impending doom
- Loss of self esteem
- Unexplained crying
- Impatience, anger and aggressive feelings-treating oneself and others harshly
- Changes in sleeping patterns—trouble falling asleep, staying asleep, sleeping too much; sleep does not give energy
- Changes in eating patterns—not wanting to eat or eating too much
- Feeling weak and tired, and taking less physical activity
- Feeling worse in the morning
- Feelings of guilt
- Reduced self-care
- Increased use of alcohol or drugs, both legal and illegal
- Slowed-up thinking, difficulty focusing, concentrating and making decisions
- Negative thoughts repeating themselves and worries of failure or not being good enough
- Feeling nervous, jumpy or restless
- Loss of touch with reality in extreme cases
- Recurrent thoughts of death or suicide or attempts to hurt oneself
- Complaints of pains such as headaches, muscle aches and pain and stomach upsets.

DSM-IV Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
E. The symptoms are not better accounted for by bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Women And Depression

Women are diagnosed with depression 1.5 times more often than men. Women tend to have more severe symptoms and to have related physical problems such as migraine headaches, thyroid problems and fibromyalgia. They also tend to have more symptoms than men, such as sleeping too much or increased appetite and weight gain, and to have other mental health problems at the same time such as anxiety, panic attacks and food issues. Women are often diagnosed with depression when in fact they have disorders of the endocrinological system, neurological disorders and other diseases such as lupus that produce depression like symptoms (Klonoff and Landrine 1997). It is important to advocate for women to get full medical check-ups to rule out physical sources of depression.

Possible Causes Of Depression

There are many theories about what causes depression, including:
- Distressing life events and significant losses or life changes
- Violence and trauma, oppression
- Issues of attachment
- Imbalance in brain chemistry
- Negative or pessimistic view of life
- Hormonal fluctuations
- Alcohol and drug use
- Financial stress
- Genetic predisposition
- Chronic illness
- Lack of sunlight

2.2.3 Postpartum Depression (PPD)

Twelve to 16% of women experience postpartum depression (PPD). This is a more severe condition than "postpartum blues," which are experienced by the majority of new mothers. The postpartum blues usually occur within two to three days of the birth and involve rapid mood swings. They usually end within two weeks without any help. If they continue, the woman may have PPD. Symptoms of PPD include:
- Lowered mood, sadness
- Tearfulness or crying
- Negative thoughts
- Feelings of worthlessness
- Anxiety or panic attacks
- Self-blame or guilt
- Worry about own health and baby's health
- Lack of energy, feeling tired
- Feeling agitated and hyperactive
- Loss of interest in activities, including sex
- Feeling irritable
- Forgetfulness
- Eating too much or too little
- Not being able to concentrate and make decisions
- Not being able to sleep when the baby is sleeping
- Feelings of hopelessness, inadequacy
- Thoughts about death and at times suicide

Postpartum Psychosis is the most severe and rare postpartum illness, occurring in approximately one in 1,000 births. It usually occurs within two weeks of childbirth, but can also take longer to appear. Women with schizophrenia or bipolar disorder or those with family histories of these diagnoses are at greater risk of developing this form of psychosis. The psychosis is the same as described in the section above, with rapid disorganized speech, agitation, lack of concentration, delusions and hallucinations (Ryan and Bodnar 2004).

DSM–IV Criteria For PPD

To indicate an episode of PPD using DSM-IV criteria, the physician or psychologist would indicate that it is an episode of major depressive disorder with the specifier "postpartum onset" (which means that the symptoms occurred within four weeks of the woman's having given birth) (Centre for Addiction and Mental Health 2007).

2.2.4 Seasonal Affective Disorder

Some people are vulnerable to a type of depression called Seasonal Affective Disorder or SAD. Generally, symptoms that recur for at least two consecutive winters, without any other explanation for the changes in mood and behaviour, indicate the presence of SAD. They may include:
- change in appetite, in particular a craving for sweet or starchy foods
- weight gain
- decreased energy
- fatigue
- tendency to oversleep
- difficulty concentrating
- irritability
- avoidance of social situations
- feelings of anxiety and despair

The symptoms of SAD generally disappear when spring arrives. For some people, this happens suddenly with a short time of heightened activity. For others, the effects of SAD gradually dissipate.

DSM-IV Criteria For SAD
Specify if, with seasonal pattern (can be applied to the pattern of major depressive episodes in bipolar I disorder, bipolar II disorder, or major depressive disorder, recurrent):

A. There has been a regular temporal relationship between the onset of major depressive episodes in bipolar I or bipolar II disorder or major depressive disorder, recurrent, and a particular time of year (e.g. regular appearance of the major depressive episode in autumn or winter).
B. Full remissions (or a change from depression to mania or hypomania) also occur at a characteristic time of year (e.g. depression disappears in the spring).
C. In the last 2 years, two major depressive episodes have occurred that demonstrate the temporal season relationship defined in criteria A and B, and no non-seasonal major depressive episode has occurred during the same period.
D. Seasonal major depressive episodes (as described above) substantially outnumber the non-seasonal major depressive episodes that may have occurred over the individual's lifetime.

Note: Do not include cases in which there is an obvious effect of season-related psychosocial stressors (e.g. regularly being unemployed each winter)

2.2.5 Anxiety Disorders

Anxiety is the most common of all mental health problems. It is estimated that anxiety disorders as they are understood by mainstream psychiatry, affect approximately one in 10 people. They are more prevalent among women than among men, and they affect children as well as adults. Anxiety disorders affect behaviour, thoughts, emotions and physical health. They involve an unusual degree of fearfulness, worry or even terror, and the frequency and intensity of these fears can be immobilizing, distressing. Anxiety problems frequently co-occur with depression or substance use problems. We include the DSM criteria for two types of anxiety disorders below.

DSM-IV Criteria For Generalized Anxiety Disorder (GAD)
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance).
B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past six months). Note: Only one item is required in children.
    1) restlessness or feeling keyed up or on edge
    2) being easily fatigued
    3) difficulty concentrating or mind going blank
    4) irritability
    5) muscle tension
    6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep).

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g. the anxiety or worry is not about having a Panic Attack (as in a Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

DSM–IV Criteria For Panic Disorder

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:
    1) palpitations, pounding heart, or accelerated heart rate
    2) sweating
    3) trembling or shaking
    4) sensations of shortness of breath or smothering
    5) feeling of choking
    6) chest pain or discomfort
    7) nausea or abdominal distress
    8) feeling dizzy, unsteady, light-headed, or faint
    9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
    10) fear of losing control or going crazy
    11) fear of dying
    12) paresthesias (numbness or tingling sensations)
    13) chills or hot flushes.

A. Both (1) and (2)
    1 recurrent unexpected Panic Attacks
    2 at least one of the attacks has been followed by one month (or more) of one (or more) of the following:
        (a) persistent concern about having additional attacks
        (b) worry about the implications of the attack or its consequences (e.g. losing control, having a heart attack, "going crazy")
        (c) a significant change in behaviour related to the attacks.

B. The Panic Attacks are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism).

C. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g. occurring on exposure to feared social situations), Specific Phobia (e.g. on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g. on exposure to dirt in someone with an obsession about

contamination), Posttraumatic Stress Disorder (e.g. in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g. in response to being away from home or close relatives).

Other Types Of Anxiety Disorder

Phobias--overwhelming feelings of terror in response to a specific object, situation or activity**.** People with *social phobia* feel a paralyzing, irrational self-consciousness about social situations. They have an intense fear of being observed or of doing something horribly wrong in front of other people. Fear of flying, fear of heights and fear of open spaces are some typical *specific phobias.*

Obsessive-Compulsive Disorder–a condition in which people suffer from persistent unwanted thoughts (obsessions) and/or rituals (compulsions) that they find impossible to control. Typically, obsessions concern contamination, doubting (such as worrying that the iron hasn't been turned off) and disturbing sexual or religious thoughts. Compulsions include washing, checking, organizing and counting.

2.2.6 Posttraumatic Stress Disorder (PTSD)

PTSD is a diagnosis that sometimes results for a person who experiences a traumatic event or series of events. PTSD is the only diagnosis in the DSM that relates a disorder to an event. In fact, the first diagnostic criterion is that a person has been exposed to a traumatic event. Conservative estimates show that 9-10% of the general population has PTSD. PTSD is associated with extremely high rate of medical and mental health service use. People who have been exposed to traumatic experiences may notice any number of symptoms in almost any combination. However, to receive the diagnosis of PTSD a person needs to meet very specific criteria.

Unidentified and untreated PTSD is usually long-term with symptoms sometimes going on for decades after the traumatic event, particularly in the case of childhood trauma. The condition is often not diagnosed until years after the traumatic event and it is common for people with the symptoms of PTSD to avoid diagnosis and treatment because of the desire to avoid reminders of the trauma. People are also commonly misdiagnosed, partly because PTSD often co-occurs with other mental health problems such as depression, bipolar disorder, substance use/dependence.

DSM-IV Criteria For Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1) efforts to avoid thoughts, feelings or conversations associated with the trauma
2) efforts to avoid activities, places or people that arouse recollections of the trauma
3) inability to recall an important aspect of the trauma
4) markedly diminished interest or participation in significant activities
5) feeling of detachment or estrangement from others
6) restricted range of affect (e.g. unable to have loving feelings)
7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) difficulty falling or staying asleep
2) irritability or outbursts of anger
3) difficulty concentrating
4) hypervigilance
5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month.
F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than three months
Chronic: if duration of symptoms is three months or more

Specify if:
With Delayed Onset: if onset of symptoms is at least six months after the stressor

2.2.7 Complex Post Traumatic Stress Disorder (PTSD)

The current PTSD diagnosis often does not capture the severe psychological harm that occurs with prolonged, repeated trauma. For example, long-term trauma may damage a healthy person's self-concept and adaptation. The symptoms of such prolonged trauma have been mistaken for character weakness. Complex PTSD is a proposed diagnosis that is used by trauma therapists to describe the many effects of repeated traumatic events, including childhood sexual abuse and sexual assault and rape for adults. Research is currently underway to determine if the Complex PTSD diagnosis is the best way to categorize the symptoms of people who have suffered prolonged trauma. Women with complex PTSD–often a result of childhood abuse--have been frequently misdiagnosed in the mental health system with Borderline Personality Disorder (BPD). Complex PTSD is not, as yet, in the DSM, so the following information has been taken from a National Centre for PTSD Fact sheet available at *http://ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_complex_ptsd.html.*

Complex PTSD
By Julia M. Whealin, Ph.D. and Laurie Slone, Ph.D.

Differences Between The Effects Of Short-term Trauma And The Effects Of Chronic Trauma?

The diagnosis of PTSD accurately describes the symptoms that result when a person experiences a short-lived trauma. For example, car accidents, natural disasters, and rape are considered traumatic events of time-limited duration. However, chronic traumas continue or repeat for months or years at a time. Clinicians and researchers have found that the current PTSD diagnosis often does not capture the severe psychological harm that occurs with such prolonged, repeated trauma. For example, ordinary, healthy people who experience chronic trauma can experience changes in their self-concept and the way they adapt to stressful events. Dr. Judith Herman of Harvard University suggests that a new diagnosis, called Complex PTSD, is needed to describe the symptoms of long-term trauma. Another name sometimes used to describe this cluster of symptoms is: Disorders of Extreme Stress Not Otherwise Specified (DESNOS).

Because results from the DSM-IV Field Trials indicated that 92% of individuals with Complex PTSD/DESNOS also met criteria for PTSD, Complex PTSD was not added as a separate diagnosis. Complex PTSD may indicate a need for special treatment considerations.

What Are Examples Of Types Of Captivity That Are Associated With Chronic Trauma?

Judith Herman notes that during long-term traumas, the victim is generally held in a state of captivity, physically or emotionally. In these situations the victim is under the control of the perpetrator and unable to flee. Examples of captivity include:

- Concentration camps
- Prisoner of war camps
- Prostitution brothels
- Long-term domestic violence
- Long-term, severe physical abuse
- Child sexual abuse
- Organized child exploitation rings

Symptoms Of Complex PTSD

The first requirement for the diagnosis is that the individual experienced a prolonged period (months to years) of total control by another. The other criteria are symptoms that tend to result from chronic victimization. These symptoms are described in the excerpt below from *First Stage Trauma Treatment: A Guide for Mental Health Professionals Working with Women*, by Lori Haskell (2003).

Simple posttraumatic stress consists of changes to three areas of functioning, while complex posttraumatic stress consists of changes to six domains of functioning. The diagnostic criteria for determining the presence of complex posttraumatic stress entails that a number of specific changes (outlined below) are present in each of the six domains of functioning.

Diagnostic Criteria For Complex Posttraumatic Stress Responses
Alteration In Regulation Of Affect And Impulses — (A And One Of B To F Required)

- **A.** affect regulation
- **B.** modulation of anger
- **C.** self-destructive behaviour
- **D.** suicidal preoccupation
- **E.** difficulty modulating sexual involvement
- **F.** excessive risk-taking

Alterations In Attention Or Consciousness — (A Or B Required)

- **A.** amnesia
- **B.** transient dissociative episodes and depersonalization

Alterations In Self-perception — (Two Of A To F Required)

- **A.** ineffectiveness
- **B.** permanent damage
- **C.** guilt and responsibility
- **D.** shame
- **E.** nobody can understand
- **F.** minimizing

Alteration In Relations With Others — (One Of A To C Required)

- **A.** inability to trust
- **B.** revictimization
- **C.** victimizing others

Somatization — (Two of A to E required)

- **A.** problems with the digestive system
- **B.** chronic pain
- **C.** cardiopulmonary symptoms
- **D.** conversion symptoms
- **E.** sexual symptoms

2.2.8 Dissociative Disorders

Dissociative Disorders (DD's) are now understood to be a fairly common effect of severe trauma in early childhood and 80-100% of those diagnosed with dissociative disorders will also have a secondary diagnosis of PTSD. Dissociation can be considered to be a highly creative survival technique, because it allows an individual to endure extremely challenging psychological circumstances while preserving some areas of healthy functioning. However, the pattern of dissociation often remains, and if it becomes chronic it can seriously affect work, social and other daily activities. Dissociation can also produce changes in memory that affect a person's sense of personal history and identity. People with DD's may experience:

This chart compares diagnostic criteria for main mental health diagnoses with the symptoms associated with complex posttraumatic stress. It is clear that many symptoms attributed to diagnoses such as borderline personality disorder, schizophrenia, bipolar disorder and others are also represented in complex posttraumatic stress. The overlap of symptoms invites service providers to consider the possible impact of severe trauma as a way of understanding the symptoms a woman is presenting.

DIAGNOSTIC CRITERION / SYMPTOMOLOGY	SCHIZOPHRENIA	SCHIZOAFFECTIVE	MAJOR DEPRESSION	BIPOLAR	BORDERLINE PERSONALITY	PTSD	COMPLEX PTS
Delusions	▼	▼		●	●		●
Hallucinations	▼	▼			●		●
Disorganized Speech	▼	▼					
Disorganized Or Catatonic Behaviour	▼	▼					
Hearing Voices	▼	▼		●			●
Social/Occupational Dysfunction:							
a) disruptions to work	▼	▼	●	●	●	●	●
b) interpersonal relations	▼	▼	●	●	●	●	●
c) self care	▼	▼	●	●	●	●	●
Depressed Mood		▼	▼	▼	●		●
Diminished Interest In Activities		▼	▼	▼			●
Significant Weight Loss Or Gain		▼	▼	▼			
Insomnia / Hypersomnia		▼	▼	▼		●	●
Fatigue		▼	▼	▼			
Feelings Of Worthlessness		▼	▼	▼	●		●
Diminished Ability To Think Or Concentrate		▼	▼	▼		●	●
Psychomotor Agitation Or Retardation		▼	▼	▼		●	●
Recurrent Thoughts Of Death / Suicidal Ideation / Attempts		▼	▼	▼	●	●	●
Irritable Mood		▼	▼	▼	●	●	●
Mood Swings		▼		▼	●	●	●
Inflated Self-esteem		▼		▼			
Racing Thoughts		▼		▼		●	●
More Talkative Or With Pressured Speech		▼		▼			
Distractibility		▼		▼		●	●
Psychomotor Agitation		▼		▼			
Excessive Involvement In Pleasurable Activities That Have A High Potential For Painful Consequences		▼		▼			
Unstable And Intense Interpersonal Relationships				●	▼		●
Avoids Imagined Or Real Abandonment				●	▼		●
Unstable Self-image					▼		●
Impulsivity				●	▼		●
Suicidal Behaviour, Threats Or Gestures				●	▼		●
Self-mutilating Behaviour					▼		●
Affective Instability				●	▼	●	●
Chronic Feelings Of Emptiness					▼		●
Intense Anger Or Difficulty Controlling Anger				●	▼	●	●
Stress-related Paranoid Ideation					▼		●
Severe Dissociative Symptoms					▼		●
Exposure To A Traumatic Event					●	▼	●
Traumatic Event Is Persistently Re-experienced						▼	●
Persistent Avoidance Of Stimuli Associated With The Event; Numbing Of General Responsiveness					●	▼	●
Persistent Symptoms Of Increased Arousal							
a) difficulty falling / staying asleep				●	●	▼	●
b) irritability				●	●	▼	●
c) difficulty concentrating				●	●	▼	●
d) hypervigilence				●	●	▼	●
e) exaggerated startle response				●	●	▼	●
Alteration In Regulation Of Affect And Impulses							
a) affect regulation				●	●		▼
b) modulation of anger				●	●		▼
c) self-destructive behaviour				●	●		▼
d) suicidal preoccupation				●	●		▼
e) difficulty modulating sexual involvement				●	●		▼
f) excessive risk taking					●		▼
Alterations In Attention Or Consciousness							
a) amnesia					●		▼
b) transient dissociative episodes and depersonalization					●		▼
Alterations In Self-perception							
a) ineffectiveness					●		▼
b) permanent damage					●		▼
c) guilt and responsibility					●		▼
d) shame					●		▼
e) nobody can understand					●		▼
f) minimizing					●		▼
Alterations In Relations With Others							
a) inability to trust					●		▼
b) revictimization					●		▼
c) victimizing others					●		▼
Somatization							
a) problems with digestive system					●		▼
b) chronic pain					●		▼
c) cardiopulmonary symptoms					●		▼
d) conversion symptoms[3]					●		▼
e) sexual symptoms					●		▼
Alterations In Systems Of Meaning							
a) despair and hopelessness				●	●		▼
b) loss of previously sustaining beliefs				●	●		▼

Key: ▼ (in shaded area) represent the diagnostic criteria listed in the DSM IV for that diagnosis. Given that complex-post traumatic stress is not yet recognized in the DSM IV, the proposed criteria are listed below. ● represent those characteristics or symptoms that are common to the presentation but are not listed in the official diagnosis. In some cases, slightly different language has been used to indicate the same or similar presentation and has been indicated by ●. For instance: insomnia is similar to difficulty sleeping, or hearing voices can sometimes overlap with dissociative phenomena, particularly in those with dissociative identity disorder.

1 According to DSM IV

2 as articulated in Haskell (2003), pp 73-74. Complex Post Traumatic Stress is currently not included in the DSM IV. It is proposed for inclusion in DSM V and may be designated as Complex Post Traumatic Stress Disorder or as Disorder of Extreme Stress, not otherwise specified (DESNOS).

3 Conversion symptoms refer to the presence of symptoms affecting voluntary motor or sensory functioning that suggest a neurological or other medical condition. Some examples include such things as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or a sensation of a lump in the throat, double vision, blindness, deafness and hallucinations. For instance a woman who grew up in a home where there was much yelling and loud raging 'arguments' has difficulty hearing in stressful situations and where there is no evidence of any hearing loss or damage to her auditory system.

- Depression
- Mood swings
- Suicidal tendencies
- Sleep disorders
- Panic attacks and phobias
- Compulsions and rituals
- Alcohol and drug use and abuse
- Psychotic-like symptoms including auditory and visual hallucinations
- Eating disorders

Like in the case of PTSD, people with DD's are often misdiagnosed, partly because the symptoms are similar to many other psychiatric diagnoses. Many will have secondary (additional) diagnoses of depression, anxiety or panic disorders (Sidran Institute).

DSM-IV Criteria For Dissociative Amnesia
A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
B. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a neurological or other general medical condition (e.g. Amnesic Disorder Due to Head Trauma).
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-IV Criteria For Depersonalization Disorder
A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g. feeling like one is in a dream).
B. During the depersonalization experience, reality testing remains intact.
C. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The depersonalization experience does not occur exclusively during the course of another mental disorder, such as Schizophrenia, Panic Disorder, Acute Stress Disorder or another Dissociative Disorder, and is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. temporal lobe epilepsy).

DSM-IV Criteria For Dissociative Fugue
A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.
B. Confusion about personal identity or assumption of a new identity (partial or complete).
C. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder and is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. temporal lobe epilepsy).
D. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

DSM-IV Criteria For Dissociative Identity Disorder

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g. blackouts or chaotic behaviour during Alcohol Intoxication) or a general medical condition (e.g. complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

2.2.9 Bipolar Disorder

Bipolar disorder is a diagnosis given to a person who has mood swings that are out of proportion with what is going on in their life. A person usually experiences both emotional highs (mania) and lows (depression) with periods of normal moods in between. It is also known as "manic depression." The pattern of symptoms differs from person to person. Some people are more prone to either mania or depression, while others experience equal numbers of manic and depressive episodes. The frequency and duration of the mood episodes also varies widely. Some people experience only one or two periods of mood disruption but most suffer from multiple, recurring manic and depressive episodes.

People who experience mania can feel that they have heightened energy, more creativity, that they have special powers or are very important. They can take more risks (for example with sex) and show poor judgment with money (spending carelessly). They may become overly talkative, jumping from one topic to another. Their moods may change rapidly and they may become anxious and irritable and blame others for their problems. They may not sleep or sleep little, and forget to eat regularly. They may lose touch with what is real and experience symptoms of psychosis such as hearing voices or having strange or disturbing ideas.

The depressive phase of bipolar disorder is similar to that of major depression, with some notable differences. Bipolar depression is more likely to include symptoms of low energy. People with bipolar depression tend to move and speak slowly and sleep a lot. They are also more likely to have psychotic depression. The depressive phase of bipolar disorder is often very severe with suicide a major risk factor (Smith et al 2007).

DSM-IV Criteria For Bipolar Disorder

Bipolar I Disorder--Diagnostic Features
The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episodes.

Bipolar II Disorder--Diagnostic Features
The essential feature of Bipolar II Disorder is a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode.

Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least one week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1) inflated self-esteem or grandiosity
2) decreased need for sleep (e.g. feels rested after only three hours of sleep)
3) more talkative than usual or pressure to keep talking
4) flight of ideas or subjective experience that thoughts are racing
5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions or foolish business investments).

C. The symptoms do not meet criteria for a Mixed Episode.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication or other treatments) or a general medical condition (e.g. hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g. medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Criteria for Mixed Episode
A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a one-week period.
B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
C. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication or other treatment) or a general medical condition (e.g. hyperthyroidism).

Hypomania
Hypomania is a less severe form of mania. People in a hypomanic state feel euphoric, energetic and productive, but their symptoms are milder than those of mania, cause less impairment to functioning and they do not experience delusions and hallucinations. They are able to carry on with their day-to-day lives. Hypomania often escalates to full-blown mania or is followed by a major depressive episode.

Criteria for Hypomanic Episode
A. A distinct period of persistently elevated, expansive or irritable mood, lasting throughout at least four days, that is clearly different from the usual non-depressed mood.
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
1) inflated self-esteem or grandiosity
2) decreased need for sleep (e.g. feels rested after only three hours of sleep)
3) more talkative than usual or pressure to keep talking
4) flight of ideas or subjective experience that thoughts are racing
5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication or other treatment) or a general medical condition (e.g. hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g. medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

2.2.10 Schizophrenia

The diagnosis of schizophrenia is given when a person has a mental health problem or "illness" that affects their thinking, emotions and sensory perception, making it hard for them to tell what is real and what is not real. Within mainstream psychiatry this experience is believed to be a brain disorder, like other disorders such as Alzheimer's or Parkinson's disease. The thinking is that the brain's chemical or electrical systems are not functioning properly, resulting in a variety of unusual neural twists, such as disjointed ideas, confused or disconnected thoughts, and sounds or other sensations experienced as real when they exist only in the person's mind. Signs of schizophrenia vary from person to person. Some of the common warning signs include:
- Sleep problems
- Social isolation
- Hyperactivity or inactivity
- Inability to concentrate
- Hostility
- Paranoia
- Unusual emotional reactions
- Deterioration in personal hygiene
- Unusual sensitivity (Kemp et al 2007)

People with schizophrenia are at a heightened risk for suicide. Schizophrenia is closely associated with the experience of psychosis. Schizophrenia is understood to be a type of psychosis, but many other conditions can also result in symptoms of psychosis, making diagnosis difficult until other explanations are ruled out.

DSM–IV Criteria For Schizophrenia
A. Characteristic symptoms: Two or more of the following, each present for a significant portion of time during a one-month period:
1) delusions
2) hallucinations
3) disorganized speech (e.g. frequent derailment or incoherence)
4) grossly disorganized or catatonic behaviour
5) negative symptoms (i.e. affective flattening, alogia, or avolition).

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: Since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations or self-care, are markedly below the level previously achieved.

C. Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A.
D. Exclusion of schizoaffective disorder and mood disorder with psychotic features.
E. Substance/general medical condition exclusion: the disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.
F. Relationship to a pervasive developmental disorder: If there is a history of autistic disorder or another pervasive development disorder, the diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

2.2.11 Psychosis

When a person is out of touch with reality this is sometimes described as psychosis. Psychosis can be experienced independently of schizophrenia and can involve:

Hallucinations—these may occur in any of the five senses and take on almost any form and range from simple sensations such as seeing lights and colors, to seeing and interacting with animals and people, and hearing voices.

Thought disorder—this can involve pressure of speech (speaking incessantly and very quickly) and flight of ideas (switching topic mid-sentence or inappropriately) and delusions (beliefs that are false, inaccurate or exaggerated, e.g. that people are after them, that they are an important personality, that they have special powers like manipulating the thoughts of others)

Personality changes—changes like mood swings, sleep disturbance, personal hygiene, talking to oneself

Lack of insight—the person is often unaware of the strangeness of their experiences; they seem normal to them

Sometimes you will not know that a person is having these experiences because they will not tell you. They may seem preoccupied and unaware of their surroundings, be talking to themselves, be responding to things you cannot see or hear, be very suspicious and fearful of others or things, be avoiding food or other things they are fearful of, have difficulty following conversations and may misinterpret the words and actions of others and be easily frightened. They may isolate themselves or use the TV or radio to tune out their voices. They may seem very distressed and frightened by what they are experiencing or they may not.

> **"I**t was like I was having a million thoughts all at once and yet I was so disorganized, nothing was getting done. I was frightened and anxious because I felt someone was trying to harm me. Increasingly, I spent most of my time alone in my room doing nothing. I didn't want to be bothered with friends or family. The television started having special messages meant only for me and I was hearing voices commenting on what I was doing. Looking back, I realize things just weren't making sense anymore. At the time though, it seemed normal and I didn't mention what was happening to me to anyone" (CMHA 2000).

Psychosis can sometimes emerge gradually over time so that in the early stages symptoms may be ignored or dismissed, but it can also appear very suddenly. Symptoms most often begin between the ages of 16–30 and men and women are equally affected. Psychosis can also be a feature of bipolar disorder, severe clinical depression, drug intoxication or overdose and withdrawal from drugs. As described in other sections of this toolkit, psychosis can be linked to childhood trauma in the same way as many other mental health problems (see Reid et al 2005).

2.2.12 Eating Disorders

Eating disorders impair the body's normal functioning, causing long-term health concerns and significantly affecting social and emotional well-being. Eating disorders include:
- not eating enough
- repeatedly eating too much in a short period of time or
- taking drastic measures to rid the body of calories consumed (purging through vomiting, overuse of diuretics or laxatives, excessive exercise or fasting).

The main types of eating disorders are:

Anorexia Nervosa—dramatic weight loss combined with an intense fear of gaining weight
Bulimia Nervosa—bouts of uncontrollable eating followed by purging
Binge or compulsive eating disorder

Although anorexia is highly publicized, bulimia is the most common type of eating disorder. Minor eating problems can later develop into serious eating disorders.

Emotional And Psychological Warning Signs Of Eating Disorders
- preoccupation with body appearance or weight
- moodiness, irritability
- reduced concentration, memory and thinking ability
- anxiety, depression or suicidal thoughts
- anxiety around meal times
- guilt or self-hatred

Behavioural Warning Signs Of Eating Disorders
- dieting or making frequent excuses not to eat
- overeating
- obsessive rituals such as drinking only out of a certain cup, or eating certain foods on certain days
- wearing baggy clothes, or a change in clothing style
- hoarding food
- trips to the bathroom after meals

Social Warning Signs Of Eating Disorders
- social withdrawal or isolation
- avoidance of social situations involving food
- decreased interest in hobbies

Physical Warning Signs Of Eating Disorders
- weight loss or rapid fluctuation in weight
- changes in hair, skin, and nails (dry and brittle)
- dehydration or edema (retention of body fluid, giving a "puffy" appearance)
- loss or irregularity of menstrual periods
- reduced metabolic rate (can lead to slow heart rate, low blood pressure, reduced body temperature, and bluish-coloured extremities); sensitivity to the cold
- hypoglycemia (low blood glucose levels), which can cause confusion, illogical thinking, coma, shakiness and irritability

- faintness, dizziness, or fatigue
- reduced concentration, memory and thinking ability
- bowel problems such as constipation, diarrhea or cramps
- sore throat, indigestion and heartburn
- easy bruising (Segal et al 2007)

A feminist approach to eating problems or "disorders" draws attention to the fact that dangerous behaviours associated with eating problems exist on a wider continuum of behaviours that are linked strongly to food and body image issues that most women face in Western society due to sexism.

DSM–IV Criteria For Anorexia

A. A refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to a maintenance of body weight less than 85% of that expected, or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Specify type:
Restricting Type: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics or enemas)

Binge–Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas).

DSM–IV Criteria For Bulimia Nervosa

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    a) eating, in a discrete period of time (e.g. within any two-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
    b) a sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating)
2. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for three months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:
Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

2.2.13 Personality Disorders

Mainstream psychiatry views personality disorders as "pervasive chronic psychological disorders, which can greatly affect a person's life" *(www.helpguide.org)*. Personality disorders exist on a continuum so they can be mild to more severe in terms of how pervasive and to what extent a person exhibits the features of a particular personality disorder. While most people can live pretty normal lives with mild personality disorders (or more simply, personality traits), during times of increased stress or external pressures (work, family, a new relationship, etc.), the symptoms of the personality disorder will gain strength and begin to seriously interfere with their emotional and psychological functioning.

Those diagnosed with a personality disorder are thought to have disturbances in: self-image, the ability to have successful interpersonal relationships, appropriateness of range of emotion, impulse control and ways of perceiving themselves, others, and the world. These disturbances come together to create a pervasive pattern of behaviour and inner experience that is quite different from the norms of the individual's culture and that often tend to be expressed in behaviours that appear more dramatic than what society considers usual. Therefore, those with a personality disorder often experience conflicts with other people and vice-versa *(http://www.helpguide.org)*. There are ten different types of personality disorders, including:
- Borderline Personality Disorder
- Paranoid Personality Disorder
- Anti-social Personality Disorder

DSM–IV Criteria For Borderline Personality Disorder
The features understood to be associated with Borderline Personality Disorder are:
A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1) Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.
2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3) Identity disturbance: markedly and persistently unstable self-image or sense of self.
4) Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.
5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6) Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
7) Chronic feelings of emptiness.
8) Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

The connections between this diagnosis and the behaviours of those with childhood trauma histories have not gone unnoticed (Inequality Agenda 2005).

A large number of commentators have critiqued the use of the personality disorder category from many different perspectives, including feminist perspectives. Critics believe that those labelled with personality disorder have had neglectful, abusive and traumatic childhoods with consequent difficulties in forming

attachments. Many in the mental health field now believe these diagnoses to be unhelpful categories and their use is declining in many clinical settings. Women with trauma histories have traditionally been misdiagnosed as having Borderline Personality Disorder and this has been a label that has created huge additional problems for women, in part because of the idea that personality disorders are untreatable.

Types Of Involvement With Substances

2.2.14 Substance Use Disorders
(Material in this section taken or adapted from Dorsey et al 2007 and 2007a)

These refer to excess use of alcohol or legal/illegal drugs leading to significant social, occupational and medical problems. Substance use occurs along a spectrum where addiction is just one type of problematic use. The range of this spectrum extends from potentially problematic use through use that involves negative consequences to addiction. At any point on this spectrum it is possible to intervene in a way that reduces harm. Generally, when substance use creates life problems and/or becomes compulsive it becomes an identifiable disorder.

Addiction is use of a substance or behaviour that is characterized by preoccupation with one or more substances or behaviours, loss of control, and continued use or involvement despite negative consequences.

2.2.15 Alcohol Abuse

Signs and symptoms that may indicate that an addictive relationship to alcohol:
* Drinking alone or in secret
* Not remembering conversations or commitments—sometimes referred to as "blacking out"
* Making a ritual of having drinks before, with or after dinner and becoming annoyed when this ritual is disturbed or questioned
* Losing interest in activities and hobbies that used to bring pleasure
* Irritability as usual drinking time nears, especially if alcohol isn't available
* Keeping alcohol in unlikely places at home, at work or in the car
* Gulping drinks, ordering doubles, becoming intoxicated intentionally to feel good or drinking to feel "normal"
* Having legal problems or problems with relationships, employment or finances

2.2.16 Alcohol Addiction

The following factors may indicate that an alcohol problem has developed into an addiction to alcohol:
Craving–A strong need, or urge, to drink
Loss of control–Not being able to stop drinking once drinking has begun
Physical dependence–Withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety after stopping drinking
Tolerance–The need to drink greater amounts of alcohol to get high.

People who are addicted to alcohol:
* Experience negative consequences associated with drinking but continue to drink despite those consequences.
* Set limits on how much or how often they will drink but unexpectedly exceed those limits.
* Promise themselves and/or other people that they will drink in moderation but break those promises.
* Feel guilty or remorseful about their drinking but still fail to permanently alter the way they drink.
* Get complaints about their drinking and resent, discount, and/or disregard those comments and complaints.

2.2.17 Drug Use/Misuse/Abuse/Dependency[1]

Drug abuse, also known as substance abuse, involves the repeated and excessive use of a drug to produce pleasure or escape reality—despite its destructive effects. The substances abused can be illegal drugs such as heroin and cocaine, or legal substances used improperly, such as prescription drugs and inhalants like nail polish or gasoline.

Substance abuse can be identified by the way in which it takes over a person's life, disrupting relationships, daily functioning and peace of mind. Using a drug to numb unpleasant feelings, to relax, or to satisfy cravings are examples of psychological addiction. Physical addiction is characterized by tolerance—the need for increasingly larger doses in order to achieve the initial effect—and withdrawal symptoms when the user stops.

The more drug use begins to affect and control a person's life, the more likely it is that he or she has a drug problem. Signs and symptoms of misuse/addiction include:
- Inability to relax or have fun without doing drugs—giving up other activities previously enjoyed
- Sudden changes in work or school attendance and quality of work or grades
- Frequently borrowing money, selling possessions or stealing items from employer, home, or school
- Angry outbursts, mood swings, irritability, manic behaviour or overall attitude change
- Talking incoherently or making inappropriate remarks
- Deterioration of physical appearance and grooming
- Wearing sunglasses and/or long-sleeved shirts frequently or at inappropriate times to hide signs of drug use
- No longer spending time with friends who don't use drugs and/or associating with known users
- Engaging in secretive or suspicious behaviours, such as making frequent trips to the restroom, basement or other isolated areas where drug use would be undisturbed
- Talking about drugs all the time and pressuring others to use
- Doing more drugs than intending to, more frequently or in larger amounts
- Expressing feelings of exhaustion, depression and hopelessness
- Using drugs first thing in the morning
- Increased tolerance—needing to use more of the drug to achieve the same effect
- Experiencing withdrawal symptoms such as nausea, restlessness, anxiety, tremors and taking a drug in order to avoid withdrawal symptoms
- Legal, social, work or interpersonal problems due to drug use
- Inability to stop using

DSM-IV Substance Abuse Criteria

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:

1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).

2) Recurrent substance use in situations in which it is physically hazardous (such as driving an automobile or operating a machine when impaired by substance use)

3) Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct)

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1   We are using the common terminology here when describing how these issues are defined, e.g. abuse. In the rest of the toolkit we will be using the terms problem substance use or addiction rather than abuse, misuse or chemical dependency.

4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights). Alternatively, the symptoms have never met the criteria for substance dependence for this class of substance.

DSM-IV Substance Dependence Criteria

Addiction (termed substance dependence by the American Psychiatric Association) 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 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 the desired effect

or

(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

or

(b) The same (or 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 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, use the substance, or recover from its effects.

6) Important social, occupational, or recreational activities are given up or reduced because of substance use.

2.2.18 Concurrent Disorders Or Dual Diagnosis

This is the term used to describe a person who has a chemical dependency as well as a mental health problem or psychiatric illness. Many of the symptoms of drug abuse (such as extreme anxiety, depression, paranoia, delusions and hallucinations) are similar to those of mental illness. Many of the effects on one's life (severe decline in self-care and functioning) may also be similar. Often, one problem is blamed on the other. The substance use may be more visible and mask the presence of a mental health problem. Substance abuse complicates almost every aspect of care for a person with a mental illness (Elam et al 2007). For more information see the section Trauma, Mental Health and Substance Use Within an Anti-Oppression Perspective.

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Please see the website *www.heretohelp.bc.ca* for user-friendly information on mental health and substance use problems. This contains a number of factsheets about different mental health and substance use problems.

The webguide *www.helpguide.org* may also be helpful. Keep in mind that both of these resources largely take a medical self-management perspective and are uncritical of the dominant perspective on mental health.

Another useful resource on different types of psychological distress is the Counselling Resource website at *http://counsellingresource.com/distress/index.html.*

A psychology online resource with lots of information about diagnoses is *http://allpsych.com/*

A website that provides articles and resources on working with trauma and dissociation is the Sidran Institute website *www.sidran.org.*

2.3 Medications, Side Effects and Functions/Effects of Licit and Illicit Drugs

BY TESSA PARKES

Introduction

This section aims to introduce you to the main types of medication used for mental health problems and to the main licit and illicit drugs used by women. This is in order for you to better understand the experiences of women who use the mental health system, get prescribed psychiatric medications and use drugs. It is not suggesting that medication is the best or only way to treat mental health problems. It simply acknowledges that many women whom you work with will have been prescribed some form of psychiatric medication and that our role can be strengthened if we have some information about these treatments. It is important that this be read with the sections Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective and Broadening the Lens and Moving Towards Empowerment, which contextualize the information below by providing a critical perspective on mental health and substance use interventions and treatments.

It is also important to remember that a woman's use of medication and drugs/alcohol can affect her safety. Medication is also therefore discussed in the sections on safety planning with women with mental health problems and drug/alcohol use is discussed in the section on safety planning with women with substance use concerns.

2.3.1 Medication For Mental Health Problems

Medication is one form of treatment for mental health problems and aims to control the acute symptoms of these problems or illnesses and to prevent relapse. It is usually the treatment of choice in public mental health services.

> More than 5,000 prescription drugs are available in Canada, and physicians write about 250 million prescriptions annually in addition, approximately 17,000 medications are available without prescription (Alberta Alcohol and Drug Abuse Commission 2003)

We have included a summary table of the main psychiatric medications, their generic and brand names, common side effects and comments below. This has been taken from the BC Mental Health Guide (May 2006) with kind permission from the Canadian Mental Health Association.

Please note the following disclaimer from CMHA: "This guide provides general information only and is not intended to replace the guidance of a qualified physician. Whilst CMHA endeavours to keep this information up-to-date and correct, we cannot guarantee its completeness or accuracy: always consult with a qualified physician before taking or changing any medication".

2.3.2 Medication Table

	ANTIDEPRESSANTS	ANTIPSYCHOTICS	MOOD STABILIZERS	ANXIOLYTICS
What Is It?	Used to treat or control depression	Also known as neuroleptics, major tranquilizers. Used to treat psychotic illness (schizophrenia and mania). These medications are also used in resistant depression and in children with behavioural outbursts.	Used to treat people in a state of great excitement, emotional stress, and/or depression.	Also known as tranquilizers, sedatives. Used to relieve the distress of anxiety.
Some Examples Generic name followed by trade name in brackets	**MAOI** Phenelzine (Nardil) Tranylcpromine (Parnate) **RIMA** Moclobemide (Manerix) **Tricyclics** Amitriptyline (Elavil) Clomipramide (Anafranil) Desipramine (Norpramin) Imipramine (Janimine) Nortripyline (Aventyl) **SSRI** Citalopram (Celexa) Fluoxetine (Prozac) Fluvoxamine (Luvox) Paroxetine (Paxil) Sertraline (Zoloft) **SNRI** Venlafaxine (Effexor) **Various** Buprion (Wellbutrin) Mirtazapine (Remeron) Trazodone (Desyrel)	**Typicals** Chlorpromazine (Thorazine) Fluphenazine (Moditen, Modicate) Flupenthixol (Fluanxol) Fluspirilene (Imap) Haloperidol (Haldol) Loxapine (Lozpac) Mesoridazine (Serentil) Methotrimeprazine (Nozinan) Perphenazine (Etrafon) Pimozide (Orap) Pipotiazine (Piportil) Sulpiride Thiothixene (Navene) Zuclipenthixol (Clopixol) **Atypicals** Rispiridone (Risperdal) Long-acting Rispiridone (Risperdal Consta) Olanzapine (Zyperxa) Clozapine (Clozaril) Quetiapine (Seroquel)	Carbamazapine (Tegretol) Divalproex (Depakote) Lithium Carbonate (Carbolith) Valproic Acid (Depakene)	Alprazolam (Xanac) Bromazepam (Lectopam) Buspirone (Buspar) Clonazepam (Klonopin) Chloradiazepoxide Diazepam (Valium) Flurazapam (Dalmane) Lorazepam (Ativan) Midazolam (Versed) Nitrazepam (Mogadon) Oxazepam (Serax) Temazepam (Restoril) Triazolam (Halcion) Zopiclone (Imovane)
Common Side Or Unwanted Effects	Headache and stomach ache at onset of medication. Less common: Dry mouth, blurred vision, difficulty urinating, constipation, sedation, dizziness.	Drowsiness, dizziness, dry mouth, movement problems, stiff muscles, weight gain.	Lethargy, trembling, nausea, diarrhea, frequent urination, mental functioning problems.	Sedation, lethargy, depression, difficulty concentrating, memory problems.
Comments	• Medication takes several weeks to reach full effect • Caution is needed by elderly people when taking anti-depressants. • Not addictive but should never be stopped abruptly • There are worse side effects if these medications are stopped without a tapering schedule.	• There is the need for medical follow-up to check blood sugar levels and lipid levels. • Tardive Dyskinesia (TD) or involuntary movements may occur when used for long periods of time • Managing side effects may be achieved by changing dosage, or adding medication (benztropine, procyladine, triheyphenidyl) for movement side effects.	• Medication takes several weeks to take effect • Regular blood tests are required for measuring medication levels.	Dependency can occur with these medications at any time.

2.3.3 Women And Benzodiazepines

The high rates of licit substance use among women is commonly overlooked and the negative health impacts minimized. Women can be supported to come off tranquilizers such as benzodiazepines over time with experienced and gradual medical support. The side effects of withdrawing from this family of drugs can be very uncomfortable and severe. Unfortunately, benzodiazepine addiction in women has not received sufficient attention in health promotion, illness prevention or addictions treatment.

The website *Our Bodies, Our Selves Health Resource Centre* lists many useful resources connected to this topic: *http://www.ourbodiesourselves.org/book/companion.asp?id=3&compID=118*.

Another excellent resource is the report by the BC Centre for Excellence in Women's Health called *Manufacturing Addiction: The overprescription of benzodiazepines and sleeping pills to women in Canada* at *http://www.benzo.org.uk/amisc/benzobrief.pdf*.

2.3.4 Women And Anti-Depressant Medications

For more information, see *SSRI antidepressants: their place in women's lives* at *www.whp-apsf.ca/en/documents/ssri.html*. Also see *The Marketization of Depression: The prescribing of SSRI antidepressants to women* at *http://www.whp-apsf.ca/pdf/SSRIs.pdf*.

Talking With Women About Their Medications

It can be helpful for a woman to talk about the medications she is taking and the impact of these on her life, her health and her safety. Having a conversation about her medication can help her to understand more about how the drugs may be affecting her, including any side effects. You may like to consider asking her to bring all her medications in so that you can write them down, including the dose she is taking. You could suggest looking up the medications on the Internet to find out the standard use of the drug, the expected effect and the side effects. This can help women to have more informed conversations with their mental health service providers and help you be a better advocate for them. Easy-to-use information on Canadian prescription drugs is available at *http://www.medbroadcast.com/drug_info.asp*. Information on drugs and their side effects can also be found at *http://allpsych.com/meds.html*.

2.3.5 Psychotropic Drugs And Posttraumatic Stress

Some medications are used to treat posttraumatic stress, because of the research findings that trauma causes alterations in stress hormone secretions and memory functioning (Fisher and Choquette 1999). They are usually given to enable a person to engage in therapy by reducing the impact of painful and disturbing symptoms. Carefully monitored medications emerging from holistic diagnosis and service provider collaborations are now considered to be helpful to the trauma survivor.

The medications most commonly used are antidepressants, antipsychotics and antianxiety agents. They tend to be used differently from how they are used with other mental health problems: usually in much smaller doses. The SSRI antidepressant medications can be effective in reducing anxiety symptoms, nightmares and flashbacks, treating sleeping disturbances and improving concentration. Antipsychotic medications such as Respiridone, Loxapine and Olanzapine are sometimes used in small doses to treat hyperarousal symptoms and they seem to help some women to stay grounded and focused on the present (Fisher and Choquette 1999). Anti-anxiety medications are sometimes used on a short-term basis to relieve panic and anxiety symptoms and to help to promote sleep. The use of this type of medication is more controversial because of the danger of increasing the numbing response to trauma.

No Charge Medications—Plan G

There is a no-charge psychiatric medication program in BC that assists people for whom the cost of these medications is a serious barrier but who, without medication, would suffer very serious consequences, such as hospitalization. This program provides psychiatric and side effect medication approved by Pharmacare (except sleeping pills) at no cost to the individual. To be eligible, a person must have a net adjusted income of less than $24,000 plus $3,000 for each dependent, and a physician must state that they meet the clinical criteria. To apply, a person must bring a doctor's form and their prescription to their local mental health centre. If approved, the medication can then be received at no cost from any pharmacy. Forms are available at mental health centres or online at www.healthservices.gov.bc.ca/exforms.

The side effects of withdrawing from benzodiazepines (including Xanax, Clonazepam and Ativan) can be very uncomfortable if not severe. Women benefit from emotional and medical support over a gradual withdrawal process.

2.3.6 Functions Of Licit And Illicit Substances

The whole of this section has been taken, with permission, from an excellent resource on drugs by Watari—a Vancouver based youth, family and community service (see *www.watari.org*). We have made some small adjustments.

Stimulants

CAFFEINE
Types (other names) Coffee; caffeine pills; cola; chocolate; used in some medications
Physiological effects Increased heart rate; increased blood pressure; euphoria; breathing tubes open up; pupils dilate; muscles tighten
Other uses Caffeine—cardiac stimulant; diuretic (increases urine production)
Why (effect sought) Increased energy; increased alertness; mild euphoria
Why not (side effects and negative consequences) Anxiety; stomach upset; irritability; physical and psychological dependence (addiction); withdrawal symptoms include: severe headache, fatigue, irritability, depression and anxiety.

NICOTINE
Types (other names) Cigarettes; cigars; snuff; chewing tobacco
Physiological effects Increased heart rate and blood pressure; breathing tubes open up; pupils dilate; muscles tighten
Other uses Tobacco is used in some First Nations communities for ceremonial purposes
Why (effect sought) Increased energy; increased alertness, mild euphoria; manage stress and emotions; social acceptance; physical and psychological dependence (addiction)
Why not (side effects and negative consequences) Heart disease; heart attacks; strokes, emphysema lung disease; cancers of the throat, mouth, lungs, dulls sense of smell and taste, addiction; tremors; stomach ulcers; lower Vitamin C levels; reduces immunity to disease; skin wounds heal more slowly; first time users may experience diarrhea, dizziness and vomiting; second hand smoke; physical and psychological dependence (addiction)

COCAINE

Types (other names)
Cocaine (coke, snow, flake, powder, blow, free-base, crack, rock)

Physiological effects
Increased heart; increased blood pressure; increased temperature; dilated pupils; euphoria

Other uses
Local anaesthetic

Why (effect sought)
Increased energy; increased alertness; euphoria; manage stress and emotions; temporary escape from problems; eases boredom, temporary relief from problems

Why not (side effects and negative consequences)
Impairs decision-making; restlessness; anxiety; irritability; aggressive/violent behaviour; mental health problems including paranoia and psychosis; financial problems; legal problems; personal problems; hepatitis; HIV/AIDS; sudden death; physical and psychological dependence

CRYSTAL METHAMPHETAMINE

Types (other names)
Crystal methamphetamine (crystal meth, crystal, jib, ice, crank, speed)

Physiological effects
Increased heart rate and blood pressure; sweating; dilated pupils; decreased appetite; rapid breathing

Other uses
None

Why (effect sought)
Increased energy; increased alertness; euphoria; manage stress and emotions; temporary escape from problems; eases boredom

Why not (side effects and negative consequences)
Impairs decision-making; restlessness; anxiety; irritability; aggressive/violent behaviour; mental health problems including paranoia and psychosis; hallucinations; legal and financial problems; personal problems; hepatitis; HIV/AIDS; sudden death; physical and psychological dependence (addiction); risky sexual behaviours (increase in STD transmission)

Tobacco is used in some First Nations communities for ceremonial purposes.

Depressants

ALCOHOL

Types (other names)
Beer; wine; champagne; cider; coolers; 'hard lemonade'; vodka; gin; rum; scotch/whiskey; rye

Physiological effects
Decreased heart rate; decreased blood pressure

Other uses
Sometimes used in medication

Why (effect sought)
Euphoria; social confidence; helps manage stress; helps manage depression; temporary relief from problems; eases boredom; social acceptance; to '"loosen up" or feel more gregarious; to relax and unwind; to feel more powerful

Why not (side effects and negative consequences)
Impairs decision making; hangovers; blackouts; unconsciousness; coma; death; liver disease; stomach cancer; cardiovascular problems; physical and psychological dependence (addiction); legal and financial problems; personal problems; Korsakoff's syndrome (alcoholic dementia); Fetal Alcohol Spectrum Disorder

OPIATES

Types (other names)
Heroin; morphine; opium; methadone; codeine; Demerol; Dilaudid

Physiological effects
Decreased heart rate; decreased blood pressure; contracted pupils; menstrual irregularities; dizziness

Other uses
Pain relief; codeine in cold and cough medications; methadone used to manage heroin addiction

Why (effect sought)
Calming; relaxing; euphoria; pain relief; helps to manage stress; helps manage depression; temporary relief from problems; eases boredom

Why not (side effects and negative consequences)
Impairs decision-making; physical and psychological dependence (addiction); nausea, constipation; decreased alertness and concentration; mild anxiety; slowed breathing; legal and financial problems; personal problems; HIV/AIDS; hepatitis; unconsciousness; coma; overdose death

Women suffering from PTSD may be prescribed an antidepressant, antipsychotic or antianxiety medication.

SEDATIVES / HYPNOTICS

Types (other names)
Benzodiazepines: Rohypnol (date rape drug), Valium, Ativan
Barbiturates: GHB (date rape drug), Seconal, Immovane

Physiological effects
Decreased heart rate; decreased blood pressure

Other uses
Used to treat: sleep problems, anxiety, tension, high blood pressure and seizures

Why (effect sought)
Calming; relaxing; reduces anxiety and nervousness; feeling of wellbeing; reduces muscle tension and alertness; temporary relief from problems

Why not (side effects and negative consequences)
Overdose; coma; slurred speech; impaired sense of time and space; impaired thinking; confusion; physical and psychological dependence (addiction)

SOLVENT / INHALANTS

Types (other names)
Cleaning fluids, fast-drying glues; inhalants; aerosols; paint thinners and removers; gasoline

Physiological effects
Breathing slowing down; heart beat/rate are slowed down; watering of the eyes; sneezing; coughing; nasal inflammation

Other uses

Why (effect sought)
Euphoria; light-headedness; exhilaration; vivid fantasies; temporary relief from problems

Why not (side effects and negative consequences)
Recklessness; feelings of invincibility; suffocation; explosions; burns; self-destructive and suicidal behaviour; death can occur if person is startled or engages in strenuous activity while intoxicated; psychological dependence

Steroid use can result in insomnia, depression, mania, psychosis and aggression.

Hallucinogens

LSD, PSILOCYBIN, MESCALINE, PCP

Types (other names)
LSD (acid, cid): Psilocybin (mushrooms, 'shrooms): Mescaline (peyote): PCP (angel dust)

Physiological effects
Dilation of pupils; increased blood pressure, increased heart rate

Other uses
Used in some cultures in spiritual ceremonies

Why (effect sought)
Joy; inspiration; euphoria; intensifies perception; brightens colours; objects seem sharper or distorted; time distorted; distance distorted; temporary relief from problems

Why not (side effects and negative consequences)
Thinking distorted; concentration distorted; perception distorted; extreme mood swings; anxiety; aggression; terror; paranoia; confusion; "bad trip"; flashbacks; accidental death; mental health problems; psychological dependence

MDA, MDMA

Types (other names)
Ecstasy: E, XTC, love drug, X

Physiological effects
Pupils dilate; increased heart rate; increased blood pressure; sweating

Other uses

Why (effect sought)
Euphoria; pleasure; empathy; heightened sensations; heightened emotions; increased sociability; temporary relief from problems

Why not (side effects and negative consequences)
Distorted perception; anxiety; depression; kidney failure; heart failure; dehydration; muscle tension; teeth clenching; psychological dependence

MDA & MDMA also known as Ecstasy can cause anxiety and depression.

Other

CANNABIS

Types (other names)
Marijuana (pot, weed, blunt, sticky icky, hydro, grass, reefer, ganja, joint): hash; hash oil (honey)

Physiological effects
Impaired coordination and balance, red eyes, dry mouth and throat

Other uses
Used to treat nausea and vomiting; multiple sclerosis, glaucoma, epilepsy and people with severe weight loss, anorexia and wasting syndrome associated with AIDS

Why (effect sought)
Calming; relaxing; increases sociability; talkative; increases appetite; enhanced sensory perception

Why not (side effects and negative consequences)
Anxiety; paranoia; confusion; impaired memory; impaired concentration; impaired problem-solving abilities; triggers schizophrenia; psychological dependence

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STEROIDS

Types (other names)
'roids

Physiological effects
Physical vigour; feelings of wellbeing; anxiety; irritability; aggression (roid rage), insomnia; depression; mania; psychosis

Other uses
Used to treat anaemia, breast cancer, osteoporosis, tissue wasting and in veterinary medicine

Why (effect sought)
Muscle development; increase in strength; increase in endurance (not scientifically proven)

Why not (side effects and negative consequences)
Liver damage and cancer; jaundice; high blood pressure; high cholesterol; acne; trembling; may stunt growth in adolescents; women – deepening of voice, development of body hair, breast reduction, interferes with menstruation; men – baldness, shrinkage of testicles, reduced sperm count, testicle and prostate cancers, enlargement of breasts.

For more information on the effects of different drugs on women's health and possible fetal effects during pregnancy see the resources at the Alberta Alcohol and Drug Abuse Commission, *www.aadac.org,* and The Prima Project at *www.addictionpregnancy.ca/home.html.*

What Happens When You Mix Drugs?

Mixing drugs can cause unwanted and unexpected effects. When combining one substance with another it is not 1 + 1 = 2; it is more like 1 + 1 = 4. This is called the synergistic effect. Combining 2 depressants–such as alcohol and a sedative or heroin–can easily lead to an overdose.

What Is The "Date Rape Drug?"

There are 2 drugs that are referred to as the "date rape drug:" Rohypnol and GHB. Both are used as recreational drugs but in higher concentrations can cause loss of consciousness and memory. GHB is particularly dangerous because in liquid form it has no smell, taste or colour and can easily be added to someone's drink without their knowledge (Taken from *All About Drugs* by Watari).

2.3.7 Medications Most Likely To Be Sold On The Streets

- Tylenol 3 (T3's)
- Benzodiazepines: Valium, Rivotril (rivvies), Ativan, Clonazepam (blues and yellow), Rohypnol (roofies, roachies, La Roche, rope, rophies, ruffies)
- Dilaudid, an opiate (dillies, juice)
- Methadone: see Appendix 2 for information on this drug
- Talwin and Ritalin: Talwin is a narcotic painkiller and Ritalin is a stimulant (T and R's)
- Oxycontin: contains oxycodone, a timed-release painkiller which is opiate-based (oxy, OC)
- Percocet: an opioid pain reliever, contains acetaminophen (percs)

It is safe to assume that anything that acts as a painkiller, sedative or stimulant gets sold and used on the street.

2.3.8 References, Resources and Further Reading

Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. 2006. *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview.* Available at www.cwhn.ca.

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Currie, J. 2003. *Manufacturing Addiction: The overprescription of benzodiazepines and sleeping pills to women in Canada.* Vancouver: BCCEWH.

Howard, D. E and Wang, M, Q. 2003. Risk profiles of adolescent girls who were victims of dating violence. *Adolescence,* 38 (149): 1–14.

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Poole, N. 2004. Substance use by girls and women: Taking gender into account in prevention and treatment. *Visions: BC's Mental Health and Addictions Journal: Concurrent Disorders2 (1): 15.*

Poole, N. & Dell, C. A. 2005. *Girls, Women and Substance Abuse.* Vancouver: BCCEWH and Canadian Centre for Substance Abuse.

Rutman, D. et al. 2000. *Substance Use and Pregnancy: Conceiving women in the policy making process.* Ottawa: Status of Women Canada.

Watari: Youth, Family and Community Services. Undated. *All About Drugs.* Vancouver.

For more information on women and benzodiazepines see the Women's Addiction Foundation information sheet online at *http://www.womenfdn.org/Resources/info/benzolng.htm* and *http://www.womenfdn.org/Resources/info/pdfs/benzo.pdf.*

Our Bodies, Our Selves Health Resource Centre lists many useful resources: *http://www.ourbodiesourselves.org/book/companion.asp?id=3&compID=118*

Manufacturing Addiction: The overprescription of benzodiazepines and sleeping pills to women in Canada at *http://www.benzo.org.uk/amisc/benzobrief.pdf*

SSRI antidepressants: their place in women's lives by Diane Saibil in collaboration with Women and Health Protection
www.whp-apsf.ca/en/documents/ssri.html

The Marketization of Depression: The prescribing of SSRI antidepressants to women by Janet Currie at *http://www.whp-apsf.ca/pdf/SSRIs.pdf.*

Watari

www.watari.org

WATARI's mission is to facilitate positive change in at-risk children, youth, families and communities through the design and delivery of innovative services.

CAMH

http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/index.html

A Canadian research facility based in Toronto that produces a range of materials concerning mental health and addictions to help clients and their families, professionals and the general public to learn more about addiction and mental health issues. Contains excellent drug information fact sheets on all drugs (see Appendix 2 for example on methadone) including some fact sheets written for those using those drugs with harm reduction information highlighted. Also many helpful tips, frequently asked questions and best practice/ emerging knowledge in this area. Many very accessible resources that are easily downloaded to use with clients such as the *Methadone Maintenance Treatment Client Handbook.*

Alberta Alcohol and Drug Abuse Commission

www.aadac.com

Excellent range of resources that provide detailed information on many aspects of addiction, drugs and alcohol including the effects of alcohol and drugs on women's health and on fetal development during pregnancy.

There is a very useful web resource available from the Alberta Alcohol and Drug Abuse Commission at *www.aadac.com* that provides detailed information on mixing medication and drugs and alcohol, including the effects of alcohol and drugs on different medications.

The Prima Project

www.addictionpregnancy.ca/home.html

This is the home of the Prima project (Pregnancy Related Issues in the Management of Addictions) designed to assist Canadian health professionals to provide care for pregnant women and new mothers using substances. Resources include information on general prenatal care for women using substances and specific fact sheets on the effects of different substances: tobacco, alcohol, opioids, cocaine and inhalants on women's health and the health of the fetus.

2.4 The Representation Agreement Act, Ulysses Agreements and Advance Directives

BY TESSA PARKES

Introduction

Some women with mental health problems will be deemed to be "lacking in capacity" at certain times. This brief overview of the Representation Agreement Act is designed to meet the specific needs of anti-violence workers and for this reason is not a complete summary of the Act. If further information is required, please consult the resources at the end of this section. The first few sections discuss the legal boundaries of the Act and its purpose and the last section focuses on more of the practical and ethical implications for anti-violence workers.

2.4.1 Summary Of The Representation Agreement Act

(The Act can be read in full online. See reference information at the end of this chapter.)

The Representation Agreement Act (RAA) came into effect in 2000 and provides a mechanism to allow adults to arrange how, when and by whom decisions about their health or personal care, financial affairs or other matters will be made, if they become incapable of making decisions independently. The Act is a foundation for all the recent adult guardianship acts and avoids the need for a court to appoint someone to help adults make decisions, or to make decisions for adults when they are not capable of making decisions independently (RAA, 1996). It reflects significant progress in the presumption of capacity, since under this Act an adult's way of communicating is not, in and of itself, grounds for deciding his or her ability to understand or make decisions about personal and health care, as well as financial and legal matters. *Indeed, until the contrary is demonstrated, every adult is presumed to be capable of making decisions about their personal and health care and of making, changing or revoking a representation agreement. The Act is founded upon a recognition that personal capacity is demonstrated in many ways and is often enhanced by supportive relationships* (Friday 2005).

In practice, a representation agreement is a legal plan that makes it clear who is given authority to make decisions if an adult over the age of 19 is unable to make decisions for themselves. An adult may name another adult, and/or the Public Guardian and Trustee, and/or a credit union or trust company (with restrictions), as his or her representative. The representation agreement authorizes the representative to help the adult make decisions, or to make decisions on behalf of the adult, about the adult's personal care and both major and minor health care, as defined in the Health Care (Consent) and Care Facility (Admission) Act, and to obtain legal services for the adult. An individual may authorize his or her representative to, for example:

a) physically restrain, move or manage the adult, or have others do so, when necessary and despite the objections of the adult;

b) give consent, in the circumstances specified in the agreement, to specified kinds of health care, even though the adult is refusing to give consent at the time the health care is provided;

c) refuse consent to specified kinds of health care, including life-supporting care or treatment;

d) make arrangements for the temporary care, education and financial support of the adult's minor children and any other persons cared for or supported by the adult (RAA, 1996).

It should be noted that a representation agreement does not deprive an adult of the power to act if they are capable; they may do anything that they have authorized a representative to do. *The main benefits of making and registering a representation agreement are that a person's wishes can be at the centre of decisions that affect them, and the person themselves can choose their preferred individuals (or body) to help them.*

When helping the adult to make decisions, or when making decisions on behalf of the adult, a representative must consult the adult to determine his or her wishes, where at all possible, and comply with these wishes if it is reasonable to do so. If the adult's instructions or expressed wishes are not known, the representative must act on the basis of the adult's known beliefs and values, and in the adult's best interests if their beliefs and values are not known. The responsibilities of a representative are to:
- Act honestly and in good faith;
- Assist the adult to make decisions or make decisions on behalf of the adult (within the authority given in the agreement);
- Keep records;
- Keep the adult's personal information confidential.

Representatives cannot do anything illegal or be expected to do things that are impossible or unreasonable and are not liable for errors, as long as they follow the RAA guidance. A representative has the right to all information and documents to which the adult is entitled and that relate to the representative's area of authority under the agreement. A representative is not usually allowed to be paid for their role. A monitor is an additional role in the RAA that may be included in a representation agreement. This person is usually a relative or friend and their role is to oversee the agreement and ensure that the representative is following their duties. Sometimes a monitor is required in law. A monitor is not generally a requirement for health and personal care decisions.

> **W**hat potential do you see for these agreements in your advocacy or counselling work?

Exceptions And Implications

If an individual is an involuntary patient in a psychiatric institution the RAA does not apply to their psychiatric care (it still applies to physical health issues). In addition, an adult may not authorize a representative to refuse consent to:
a) The adult's admission to a designated facility under section 22, 28, 29, 30 or 42 of the *Mental Health Act* (MHA);
b) The provision of professional services, care or treatment under the MHA if the adult is detained in a designated facility, under the same sections of the MHA as above;
c) The provision of professional services, care or treatment under the MHA if the adult is released on leave or transferred to an approved home under section 37 or 38 of that Act (RAA 1996: Section 11).

According to Friday (2005), mental health consumer/survivors remain in a "perilous position" despite the RAA:

> *While it is true that there is greater protection against being a "ward of the government", i.e. living under a "Certification of Incapability," consumer/survivors must still go to greater lengths to protect their own interests. This is because the provincial Mental Health Act has the power to override sections 7(1)c and 9(1)c of the RAA.*

2.4.2 Ulysses Agreements, Advance Planning, Advance Directives And Crisis Plans

Friday (2005) suggests that Ulysses Agreements offer better protection than the RAA against hospital detention and forced treatment, "especially if a support team is present to deal with hospital staff." Ulysses Agreements are sometimes known as advance plans, advance directives or crisis plans. *These agreements and plans do not have a legal status in the way the RAA agreements do, but they still involve the written expression of an individual's concerns and intentions, made when they were not acutely unwell, in the hope of influencing care, support and treatment if they do become unwell* (Van Volkingburgh 2004). If someone has a Ulysses Agreement or advance plan/directive, the support team or representative has some negotiating power with a psychiatrist or medical team, but this is not guaranteed to stop treatment being forced on a person against their will and the statements of the support team or representative.

It is possible, however, for a Ulysses Agreement to be effective in supporting a person's decision making concerning the consequences of mental health problems and their associated behaviour that may accompany these problems. *By considering and planning for a worst-case scenario, energy is put into solutions to address the person's needs when they are in crisis.* Van Volkingburgh describes the advantages of this model where parents have mental health problems and need to make plans for the care of their children when they become severely impacted by the mental health problem. She states that the planning process provides opportunities for honest communication and builds a support network for the family, allowing for special needs like interpreters and other community helpers to be more clearly involved.

Van Volkingburgh believes that advance planning can also help to break down the stigma of mental health issues by focusing on the consequences of the mental health issue rather than the person, and by breaking the silence surrounding these issues and their consequences. For example, a woman who experiences periods of extreme highs and lows may ask members of her family to act as representatives or a support team. She should clearly indicate what circumstances and behaviour would need to be present before the family would take over responsibility and exactly what she wants them to do in those circumstances. Family members then have permission from the person to act in their expressed best interests; for example, in freezing bank accounts, helping get the person treatment, and managing other personal affairs. This would only be required for an individual who becomes substantially impaired and therefore no longer able to act in their best interests.

The Representation Agreement Act (RAA) came into effect in 2000 and provides a mechanism to allow adults to arrange how, when and by whom decisions about their health or personal care, financial affairs or other matters will be made, if they become incapable of making decisions independently.

According to Van Volkingburgh (2004), a basic model of advance planning, or Ulysses Agreement, should include the following elements:

- Details such as the people named in the agreement and contact details;
- Statement of purpose including guidelines on actions to be taken by members of the individual's support team if the person becomes unwell;
- Symptoms that the person making the agreement would like others to notice and respond to, and how to respond;
- Plan of action regarding confidentiality;
- Record of individual's wishes for support services like therapy, care and treatment;
- Record of individual's wishes for care of any children and their special needs;
- How the agreement will be cancelled; and
- How the agreement will be reviewed.

Chovil (2003) adds that the plans should also contain information about current treatment, the names and contact details of health professionals and the local psychiatric facility.

In researching this section of the tool kit a number of mental health advocates were contacted and most had not heard of Ulysses Agreements or Representation Agreements. Those that had heard of them had not experienced them being used.

2.4.3 Practical Implications In STV Counselling And Advocacy Work
Consultation for this section provided by Cythera Transition House Society

Since the Representation Agreement Act (RAA) has only been in effect since 2000, its presence in counselling and victim assistance contexts has not been widely felt. It is probable, however, that as workers become more engaged in work with survivors with complex mental health issues, they will encounter situations in which a Representation Agreement or Ulysses Agreement is in place or is being sought. It is therefore important for workers to be clear what their roles may be within the context of these agreements and to be able to translate this to the women they are supporting.

The information that follows is based on the experience of one STV counsellor who supported a woman who had chosen to have a Representation Agreement in place. At the invitation of the woman, the counsellor attended a five-and-a-half-hour meeting during which the Representation Agreement was collaboratively drafted. In attendance were:
- the woman
- some of her family members (by invitation of the woman)
- numerous service providers (by invitation of the woman)
- Ministry of Children and Family Development representative.

What was key for the STV counsellor in being involved in this process was that it was at the initiative of the woman and was a vehicle for her to have a strong plan in place for the times in which she was not well. What was key to the success of this initial meeting was that the woman was in a strong, healthy place.

What emerged from the meeting was:
- a three tiered plan of intervention
- naming of behavioural cues that indicated deterioration in mental health that were specific to the woman (including thoughts/feelings/behaviours)
- identification of channels of communication if the woman was experiencing a deterioration in her mental health
- identification of actions that would be taken to ensure the woman's safety and the safety of her child at all three stages of intervention.

The role of the STV counsellor in navigating the representation agreement process with the woman was:
- preparation before the meeting to identify cues that signified deterioration in her health and what actions she might find supportive
- a willingness to be a voice for the woman regarding issues that were sensitive in the meeting; e.g. normalizing the right and need for an adult woman to be sexual and to have the right to chose her own sexual partners
- advocating for the woman in the meeting and beyond
- holding other participants in the representation agreement to appropriate roles and boundaries as identified in the agreement
- validating the woman's perception that during the times when she is unwell and others are acting for her it can feel oppressive even though it was a plan she originally initiated, and that it is not comfortable to have others take over, and it can be hard to remain committed to the plan in order to stay safe.

When the STV counsellor witnessed deterioration in the woman, she checked in with her, shared her observations and asked what the woman wanted. When the woman stated she did not want information shared, the counsellor maintained her confidentiality. Some time later another participant in the support team activated the representation agreement.

Reflective Questions

- How would you feel if you were the worker in the situation above?
- What are some of the tricky issues for you in this case?
- What supports or resources would a support team member require to play their role most effectively?
- How often should a RA/UA be reviewed to keep it current?
- How could these supports be used in situations where a woman is not used to directing others in her support needs?

One of the tricky issues in the situation above is the issue of confidentiality. It would not be uncommon for a woman, when becoming unwell, to state that she did not want the information about her mental health shared with others. However, if in designing the Representation Agreement (RA) the woman specifically stated that the support team put in place would share information with each other if they felt the Agreement needed to be activated, or may need to be activated, then that would need to be followed. The whole point of Representation Agreements is that they privilege past agreements and statements about how the support team is to act, whatever the woman may be saying in the present.

This is a very difficult issue because you may feel that you are acting out of turn if a woman tells you not to share information. However, for the RA to be overturned, or particular issues revised, the whole team

would need to be involved with the woman to revise it in a systematic manner, and crucially when the woman is in a good, strong place to be able to effectively lead this process. If there was nothing in the RA that addressed confidentiality then the support team, or members of it, may well feel that they are on shaky ground in going against a woman's expressed wishes in the here and now. Perhaps all RA's should therefore involve considerations of exactly how the support team will deal with the issue of confidentiality and the sharing of information between themselves in the event that one or more members feel that this is necessary. Decisions made that address how the sharing of information is to be handled can then be clearly highlighted in the RA with the support team members.

What are your thoughts on this? Should a plan devised in the past be able to override a woman's expressed desire in the present moment? What are the risks with this? What are the benefits? Is there discomfort in this example for us, and if so how does this affect our response? Are we afraid of losing the relationship if we honour the agreement rather than the woman's request in the moment? Can you think of better ways to balance past and present decision-making?

Conclusion

Representation and Ulysses Agreements seem like they could be effective supports in enabling women to more effectively manage their mental health ups and downs. However, they do not seem to be well utilized in practice. This may be because they are fairly new tools or because there are fundamental challenges within them, such as resolving the issues of confidentiality and the sharing of information between team members, making them difficult to implement well in practice. There may also be significant limitations to their use with individuals who are unfamiliar with or lack experience in directing their own care and being supported to make proactive advance decisions and choices in this way. This may reflect the general disempowerment of those with mental health problems within services and within society as a whole. The established tradition, within mental health services at least, has certainly been that the professional knows best, with the consumer/survivor taking a back seat in plans and interventions that aim to improve their mental health. Representation and Ulysses Agreements definitely represent a move away from this position. There is much scope for change and these agreements may indeed become part of the solution to help empower those with mental health challenges to take more control over their lives.

2.4.4 References, Resources And Further Reading

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2.5 Treatment Issues with Mental Health and Substance Use Problems

BY TESSA PARKES

2.5.1 Interventions For Mental Health Problems

> *The diagnosis a woman receives can directly determine what forms of treatment she is eligible for within the mental health system, and will greatly impact on the type and extent of care she receives* (Morrow and Chappell 1999).

The importance of being aware of the intersections between trauma, mental health and substance use has been emphasized throughout this tool kit. We have sought to acknowledge the contested nature of diagnostic labels in mental health generally and most specifically as they relate to trauma. The feminist critique of the traditional psychiatric approach emphasizes the relevance of trauma, violence, poverty and other socio-economic inequalities to women's mental health and recommends approaches that are woman-centred and focused on empowerment and addressing the root causes of women's distress (For more information and analysis please see Harris 1998, Haskell 2003, Morrow and Chappell 1999).

Despite these critiques, and a growing literature on the bio-psycho-social approach to understanding women's distress and mental health problems, there is a lack of attention to these factors in mental health policy and in the delivery of services. As Morrow and Chappell describe: "Services which recognize the specific needs of women are often dependent on the will of individual service providers and women's mental health planning is ad hoc and unsystematic".

In addition to this, it is important to remember the following issues that have been mentioned at different points throughout this kit:
- The many barriers that exist for women in accessing services
- How stigmatizing mental health diagnoses and use of the mental health system is when a woman is navigating other systems (for example, family court)
- How experiences of the mental health system can exacerbate women's existing problems through retraumatization, which can act as a major deterrent to women being willing to contact services
- The fact that some women will not have a choice in their use of mental health services due to the ability to forcibly treat under the Mental Health Act.

The aim of this section is to provide a brief guide to the main treatments and services available to women with mental health and substance use concerns in BC. In describing these services we recognize that they do not reflect a gendered analysis of women's distress and will therefore only partially address the many needs that women will have concerning their mental health. Despite this we feel that it is important to describe what services do exist so that anti-violence workers are as informed as possible in their work with women. Much of the information included in this section comes from a medical self-management model expressed in publications such as the BC Partners information on the web-based fact sheets at www.heretohelp.com.

This does not necessarily include a gendered or women-centred approach. In your work with women make sure you explore with her the services or interventions that she finds most appropriate to her situation, and where possible help her to access the information she needs to make informed choices about treatment and intervention decisions. More woman-centred, recovery-based interventions/services may be available in your area. (For more information on recovery and person-centred approaches please see the CMHA Framework for Support [Trainor et al 2004] at http://www.cmha.ca/data/1/rec_docs/120_Framework3rdEd_Eng.pdf)

2.5.2 Common Treatments for Mental Health Problems

There are a number of effective treatments and therapies for mental health problems now available. These can reduce the mental, emotional and physical impact of mental health problems and for many people can restore their quality of life completely. Different approaches work for different people and it may take a while before an individual finds a treatment approach and regime that works for them. The most effective interventions tend to be ones that start early on during the first signs of a mental health problem. This can often be difficult, however, with an understandable reluctance on behalf of individuals to seek help, in part because of the stigma involved. It is worth remembering that many women may be reluctant to seek treatment due to their history of trauma being ignored by the helping professional or concerns regarding the potential loss of children connected with having a label of mental health problems or mental illness[1]. Professionals are also becoming increasingly wary of labelling prematurely, particularly in the case of children and young people.

Common treatments include:
- **Medications:** e.g. anti-depressants, anti-psychotics (see Medications, Side Effects and Functions Effects of Licit and Illicit Drugs section for more information)
- **Therapies:** e.g. interpersonal therapies, psychodynamic therapies, feminist therapy, systemic and narrative therapies, cognitive therapies, behavioural therapies, creative therapies
- **Groups:** e.g. group counselling, self help and peer led support groups
- **Holistic/complementary therapies:** e.g. stress management and relaxation techniques, St John's wort, acupuncture, aromatherapy, massage, biofeedback methods, homeopathy, yoga, meditation, light box therapy
- **Lifestyle changes:** e.g. dietary changes, increasing social activities, exercise, vitamin supplements, getting adequate sleep and rest (*www.heretohelp.bc.ca*).

As stated above, the current mental health system is primarily bio-medically focused with a focus on the medical management of symptoms. For example, physicians recommended medication to 81% of patients who visited them for depression and to 62% of those who visited for anxiety (Pharmacare and IMS Health cited in www.heretohelp.bc.ca). Finding a medication that works, and at the right dosage, can be a long process: in part because of the many unwanted effects of psychiatric medications. Because of this many people choose to explore non-pharmaceutical options first or move towards these when they encounter severe effects of psychiatric medications. Many also combine therapies, such as medication with cognitive-behavioural therapies or interpersonal therapy with lifestyle changes.

Social support and access to financial resources are determining factors in the type of mental health care a woman can access. If dependent on government-sponsored services a woman's mental condition is more likely to be closely monitored and treatment choices limited. If she has financial resources she will be more likely to access private services which may prevent scrutiny from government and health agencies and the labelling that goes with using these services (Morrow and Chappell 1999).

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1   Many mothers lose custody of their children through their use of mental health services.

Another important aspect, particularly for women with interconnected problems of violence and/or substance use as well as mental health, is the accessibility of community supports to help with housing, income, employment, and childcare, as well as anti-violence or addictions services.

> A key factor in the success of a treatment or treatment package seems to be whether or not an individual is able to choose what treatment they want and make supported decisions about what works for them.

Many of those who have recovered from mental health issues, or managed to successfully integrate the challenges presented by the mental health issue into their everyday lives, cite the importance of a spiritual dimension to their recovery process. In fact there are a number of studies that now point to a connection between spiritual practices and better physical and mental health.

> The presence of supportive others who believe in and stand by the person affected is one of the best predictors of recovery from mental health problems. This clearly has significant implications for a woman who is in an abusive relationship, as her mental health and thus recovery may be continually undermined by her abusive partner.

2.5.3 Treatment Options For Mental Health Problems

- **Family doctors–**prescribe medications and provide referrals to specialist mental health services. They can be important advocates for access to mental health services.
- **Psychiatrists–**prescribe medication and provide psychotherapy, requires a referral from a family doctor
- **Psychologists–**(RPsych after their name) can diagnose and provide psychotherapy but not prescribe medication.
- **Clinical Counsellors–**(RCC after their name) can address clinical mental health issues through assessment, prevention, therapy and intervention but not prescribe medication.
- **RegisteredSocial Workers–**Many Employee Assistance Plans cover counselling provided by registered social workers (social workers with a Master's degree who have demonstrated experience in providing clinical counselling).
- **Mental Health Teams or Centres–**service provider teams of different kinds of professionals including social workers, nurses and mental health workers. They provide assessment, case management and coordination of treatment services, particularly for those with long standing mental health problems. A person can self-refer but referrals from family doctors are most common.
- **Peer led support services–**run by a number of different groups, sometimes affiliated with CMHA: although not "treatment" as such, they can be an important part of a person's treatment/support plan (taken from CMHA BC Mental Health Guide 2006).

N.B. While there is a lack of women-specific services there are some mental health centres that have women-only programs or women-only space, etc. Try to research what you have available in your local area. Approach your mental health services to see if they would be open to partnering with your agency to provide integrated women-specific services.

ABC Care Card will cover family doctor, psychiatrist and mental health team visits, but generally not cover sessions with psychologists or counsellors. Some Employee Assistance Programs (EAP) pay for counselling for employees. First Nations and Inuit Health Services pays for short to mid term counselling for mental health issues and trauma for First Nations and Inuit people with status.

For more information on all aspects of mental health call the BC MENTAL HEALTH INFORMATION LINE at 1-800-661-2121 or 604-669-7600. See www.heretohelp.bc.ca/connectmeto/infoline.shtml.

Free information on mental health and BC mental health services from anywhere in the province 24 hours a day, 7 days a week. Pre-recorded information on
- mental health services in BC, including your local mental health team/centre
- symptoms and causes of various mental health problems
- treatments, support groups and publications available.

Trained volunteers available 9:00 AM-4:00 PM, Monday to Friday, for personalized information and referrals.

2.5.4 Advocating For A Woman's Access To Mental Health Services

Many outside and within mental health services believe that psychiatric hospitals are not the best places for women unless they are clearly a danger to themselves or others. This is in part due to the fact that issues related to trauma are often exacerbated in these settings. Hospital can be seen as the service of last resort. However, those working in the anti-violence field need to know how to advocate for a woman's access to mental health services, including psychiatric hospital. Despite the many inadequacies of the existing system there will be times when women need and want the safety and security that can be provided in some mental health settings. For some women, hospital can offer a refuge from their lives outside. Given the cuts in service provision, accessing mental health services, including hospital services, can be very difficult for women, even with good advocacy. There are also times when service providers are legally and policy bound to report that a woman is not safe to herself, and you will want to participate in that reporting in as empowering a way as possible.

There are some specific issues to keep in mind when advocating for a woman's access to mental health services or for admission to psychiatric hospital:

- There are often *severe bed shortages and pressures on the system* so your client needs to be considered a clear priority by mental health staff before she will be admitted–don't take this personally or connect it necessarily to your organization–there are just not enough beds in the system now to accommodate all who may need them at any given time.
- The priority admissions to psychiatric hospital are now usually those who are a *danger to themselves or to others,* because of this shortage of beds. If your client does not fit in either of these categories, find out about referral pathways into mental health community teams through a family doctor, or to another more appropriate service instead.

- Try to find out what your *local hospital's admission policies* are–are there particular referral pathways you need to follow?
- If you have had a poor experience trying to get a woman the service she needs, follow this up in a constructive way with senior management to try to better understand together what happened and how things could be better next time around. Be *positive and concrete about your concerns,* including being clear about the negative impact of the situation on the woman's wellbeing.
- If your client is a danger to herself or others then you need to strongly advocate her case and you can strengthen your case in a number of ways:
    - Know the *local procedure to follow to refer* a woman to hospital and try to follow it.
    - *Find out who the gatekeepers* are and try to spend some time with them, separately from having discussions about individual clients, to talk through their referral criteria and the best ways of getting clients access to services. People may well be much more willing to talk openly in general terms outside of a crisis call. Try and find some common ground between you prior to those phone calls and develop relationships and contacts wherever this is feasible.
    - Access to mental health services is likely to be determined to some degree by the type of diagnosis a woman has. For example, women with diagnoses that are considered to be in the category of Serious Mental Illness (SMI) will be more likely to have access to services (please see History and Contributions section for more information on the definitions of Serious Mental Illness).
    - Where at all possible *take a positive rather than negative approach* to the services you are trying to access–they will obviously be more inclined to try to help you if you are polite and courteous. Whatever your past experiences have been, try to see and meet each new situation with a new approach, expecting the very best!
    - You will need to *clearly evidence your concerns concerning a woman's* safety–take good detailed notes of what your concerns are and what the woman's concerns are. If you have concerns from other professionals, or family members and friends of the client, make sure you mention these clearly and if possible get written documentation to evidence concerns held by a variety of parties–.
    - If you have a concern about *psychiatric terminology, diagnoses and labels,* this is something to set aside in these situations of trying to negotiate access to services, particularly crisis admission services. There will be an expectation that you talk, to some degree, in a way that mental health staff can relate to and respond to. Becoming familiar with the diagnostic categories does not mean that you sign up to them; –it just means that you will be able to create some common ground between you and those you are talking with in the health service. Your job is not to diagnose your clients, so all this means is being able to recognize certain behaviours and symptoms as being mental health related and to clearly communicate these to mental health staff. Using the client's words or clearly expressing concerns from family and friends is helpful.

Possible scripts to adapt…

She seems very low, is not eating and is sleeping all the time. She has told me that she is as depressed as the last time she was in hospital 18 months ago when she took all her medication in a suicide attempt.

She has been talking about ending it all and has now started making detailed plans, including arranging alternative care for the children. A good friend of hers who has known her her whole life is extremely concerned, saying that this is not like X, and I feel that she is reaching a critical danger point because she seems to be more at peace now than she was a few weeks ago. It is like she has made the decision now. Her sister is very concerned and said to me that she has never seen X as high, that she is just not herself and

is putting herself at risk doing Y and X which is not usual behaviour for her. I have seen her change too over the last 6 weeks and these are some of the things I have noticed...

She has been getting extremely fearful of strangers and this has been getting worse each week I have seen her. Now she is telling me that she is being followed everywhere she goes by the Secret Service. She has taken to staying in the house, keeping the curtains closed; she eats nothing because she fears being poisoned and tries to stay awake all night to prevent anything bad happening to her. This has been a very rapid change over the last week and I am very concerned about her.

- Talk to your colleagues about positive experiences they have had, or suggestions that worked for them. Collate these into a local set of guidelines, consult as widely as possible and then circulate to support all those that work with women in this way in your agency. Ask for regular feedback to improve the guidelines over time.
- These guidelines could also be broadened into a multi-agency protocol and be developed with local mental health and hospital staff so that the practices that are suggested are mutually satisfactory to all concerned. Developing multi-agency protocols on the issue of violence and mental heath, where all agencies sign up to particular actions as part of improving practice for the shared client group, can be one very effective way to build a shared vision for change.

> Try to build better relations between the relevant anti-violence, mental health and substance use/addiction agencies in your local area by:
> - Thinking of creative ways to improve communications between all the agencies
> - Working together to better understand respective roles and responsibilities– e.g. attend or organize a workshop that Community Co-ordination for Women's Safety[2] provides on developing a shared mission statement, or moving towards co-ordination
> - Setting up a joint forum on an area of common concern, such as women with interconnected violence, mental health and substance use issues
> - Getting important protocols and policies agreed on and written down
> - Valuing each agency's efforts at making improvements to their practice
> - Seeing beyond the negative stereotypes of each other's agencies (Adapted from Inequality Agenda 2005).

We have included a handout in Appendix 3 called *Making Connections: Women's Experience of Violence, Mental Health and Substance Use Problems* for you to use with service providers from other agencies should you wish to. The handout emphasizes the connections between trauma and violence, mental health and substance use, and contains some of the most recent research evidence documenting the connections.

2.5.5 Interventions For Substance Use Problems

> Lack of information is a key barrier for women in getting help with substance use problems.

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2   See www.endingviolence.org for more information on the training and supports that CCWS can provide to communities working on co-ordination efforts.

A range of treatment services is available to assist women with substance use problems and addiction. Often service providers have considered residential treatment to be the primary resource, but other levels of support may be better suited to women's needs.

Historically, people with substance use problems were expected to have lifelong abstinence as their goal. While abstinence remains a goal of most substance use treatment programs, there is now more focus placed on helping people choose the level and type of change they would like to make in their substance use, and to make other changes that reduce harms associated with use, such as finding adequate housing, healing from violence in their lives, etc.

> The addictions system in BC has embraced harm reduction as its foundational guiding principle. ... With harm reduction as an overarching goal and philosophy, various other goals may be appropriate for individuals at different stages of change (www.heretohelp.bc.ca).

Treatment can include medical approaches, behaviour therapy, counselling and psychotherapy, traditional healing practices, psycho-education and self help groups such as the 12 or 16 step groups[3]. Medical approaches often have the goal of stabilizing the person, and in this approach medications are used to reduce cravings, to block the effect of a certain drug, to replace another drug, or to cause unpleasant reactions when a substance is used.

> Recovery from dependence can be a lengthy process and frequently requires multiple or prolonged treatment episodes. Lapses during the course of treatment are common and do not indicate that treatment is ineffective (www. heretohelp.bc.ca).

2.5.6 Treatment Options For Substance Use Problems

- **Withdrawal management (detox)–**residential, home or outpatient support during withdrawal
- **Daytox and stabilization groups**[4]
- **Out-patient treatment–**available in most communities
- **Multi-component treatment for youth–**various constellations that vary by region
- **Intensive non-residential treatment–**day or weekend programs, clients live at home
- **Residential treatment–**intensive treatment in a structured residential context
- **Supportive recovery services–**longer-term transitional housing and support services
- **Pregnancy support services–**support services to at-risk pregnant women and their families
- **Street outreach programs–**support services and bridges to the system of care
- **Needle exchange programs–**prevent disease transmission and provide bridges to services
- **Methadone treatment–**replacement therapy for heroin addiction
- **Safe supported housing–**housing with associated support services (this is very limited)
- **Integrated trauma and substance use treatment groups–**e.g. Seeking Safety groups run by Victoria Women's Sexual Assault Centre and Nanaimo's Haven Society.

3   Sixteen Steps of Recovery and Empowerment groups are based on Charlotte Kasl's book Many Roads, One Journey–Moving Beyond the 12 Steps. They are a holistic approach to recovery from addiction. The 16-step model addresses issues of cultural diversity and internalized oppression stemming from sexism, racism, classism, and homophobia. See www.charlottekasl.com.

4   Vancouver Coastal Health and Aurora Centre offer Finding Balance and Keeping Balance groups. These are two-week groups that aim to help women to find balance in their new lives as women in early recovery. Phase I, Finding Balance, looks at ways to achieve healthier lives through exercise, nutrition, stress reduction, improving relationships, and making other positive changes. In Phase Two, Keeping Balance, women learn more about the process of addiction, and focus on improving self-esteem, communication styles, and relapse prevention strategies.

> **R**esources and services vary across the province. Call Toll Free 1-800-663-1441 or 604-660-9382. Deaf and hard of hearing callers: TTY 604-875-0885 (collect calls accepted). This is an information and referral service available 24 hours a day, 7 days a week. Outside of BC: 604-660-9382 (collect calls accepted).

Detoxification or Withdrawal Management Services provide safe places for people to withdraw from alcohol and other drugs on a 24-hour basis[5]. They also help clients to make the connections between their drug and alcohol problems and other life problems and to access other community treatment resources. They can be a source of support and friendship that can help women with parenting, mental health and abuse issues. These services often act as the gateway to other alcohol and drug services. Detox services tend to offer:

- **A quiet environment, bed rest and vitamin therapy**
- **Medical and nursing care** (e.g. help with withdrawal symptoms, sleeping, infections and other medical problems)
- **Complementary health care** (learning relaxation techniques and information or access to therapies such as acupuncture)
- **Education, counselling and support** (information about monitoring cravings, managing withdrawal symptoms and eating well, increasing motivation for change, preparing for treatment, peer support groups)
- **Information, referral and direct help in finding follow up services** (getting stabilized and improving daily living tasks such as hygiene, meal planning, finding safe housing) (Poole, undated).

> **R**egardless of whether a woman gets support on an outpatient or residential basis, she will usually need help in making a child care plan for her treatment period.

Withdrawal management is now provided in many different ways:
- At home, with family and friends providing ongoing monitoring
- At home, with volunteer providing 24-hour monitoring during physical withdrawal stage
- At home, with regular medical supervision with or without volunteer monitoring
- At a friend or volunteer's home, with or without medical supervision
- At an outpatient counselling agency that women attend during the day
- On an outreach basis where a counsellor visits at residences like transition houses
- In a residential withdrawal management program in a non-medical setting
- In a residential withdrawal program in a hospital (Poole undated).

Not all of these variations will be available to a woman, as the options will depend on local circumstances.

There are no women-only withdrawal management services in BC, except for pregnant women at BC Women's Hospital (the Fir Square Combined Care Unit).

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5 Detox services do not accept pregnant women who wish to withdraw from opiates.

Women often feel guilt and shame about their drug and alcohol use. Many women feel a particular shame about needing to use detox or withdrawal management services. Acknowledge this dynamic and help the woman to view her use of services in a positive way. Giving her as much information as possible about the specific nature of the local service she is considering using may well help to dispel the myth that detox is just for street-involved men (Poole undated).

Outpatient services provide free drug and alcohol counselling, which includes one-to-one sessions and support groups. Women counsellors should be available. Counsellors also assess treatment needs and make referrals to day or treatment programs.

Information sessions are usually available in outpatient services that give information on addiction, what to expect from treatment, the physical effects of drug and alcohol use, etc. Outpatient services can also offer a range of groups; for example, groups for women with problems with benzodiazepine addiction, or groups for lesbians.

Supportive recovery houses are drug and alcohol-free places to live while you are waiting for treatment, in treatment or coming out of treatment. These houses offer one-to-one support and group meetings. Children can often visit on weekends. Supportive recovery beds are also provided by some transition houses in BC.

Day treatment programs offer the opportunity for intensive treatment without having to leave home, and some programs give childcare subsidies for pre-schoolers. These programs run from four to five weeks, usually for three to four hours a day, usually during the week. These programs sometimes travel to rural or remote communities a few times a year. At Vancouver Coastal Health, the Family Services DEW Program for women offers intensive therapeutic group counselling in a non-residential setting (see *www.vch.ca/community/ addictions.htm*). Aurora Day Program at BC Women's also offers intensive group counselling.

Residential treatment provides a safe, supportive treatment environment to help women examine their substance use, the connections between their use and other issues in their lives, and the changes they wish to make in their substance use, physical health, emotional health, relationships and vocational situations. Residential treatment programs in BC range from three to 10 weeks. There are two women-only treatment centres in BC; Aurora Centre has a six-week program in Vancouver and Peardonville offers a 10-week program in Abbotsford. Peardonville allows women to bring their pre-school children into treatment and they attend a licensed day care. There are only six places for women with infants/children however. Other residential treatment centres offer women-only streams in their mixed gender settings.

Specialized programs exist in some areas for women who are Aboriginal, seniors or pregnant, or who have mental health issues.

Most substance use treatment focuses on abstinence, but more attention is being given to other life issues, associated with use.

Substance use in pregnancy

Drug and alcohol use during pregnancy can have negative impacts on fetal development and cause lifelong disabilities. Pregnant women therefore need support to improve their prenatal health and to stabilize and withdraw from substances as early in pregnancy as possible. *Pregnancy Outreach Programs* (POP's; see www.bcapop.ca) can be excellent supports for women and there are 46 programs across BC. They reach out to women who do not access typical prenatal information and services, and are located in community centres, health centres and friendship centres. They recognize that mental health and substance use issues may be affecting a woman's life and her ability to get support in her pregnancy. They work with women on their mental health, alcohol and/or drug issues using a strengths-based approach. They also provide introductions to new services such as specialist substance use services by going to first appointments with a woman. Alcohol and drug services give priority care to pregnant women, so be sure to mention this when looking for help for a woman you are supporting.

In general, people with lower severity problems generally need lower intensity, briefer services and those with more serious problems tend to require higher intensity and lengthier treatment. Services should be individualized and respond appropriately to gender, age and ethnicity. Some service providers insist on complete abstinence from all drugs before, during and after treatment and will discharge those found to be using. Other providers take a harm reduction approach that focuses on reducing and moderating use. Many programs address associated social, environmental, vocational, legal and family issues.

2.5.7 Making A Referral

Things to remember in helping a woman prepare for treatment

When considering referral to formal substance use treatment, try to keep the following in mind:

- It is important not to rush a woman into treatment, but to *help her consider the risks of carrying on with substance use as is,* the benefits of substance use for her (and how else she might meet these needs), the benefits of change and the costs of change. Putting into practice some of the techniques used in motivational interviewing such as decisional balance work, which examines readiness for change as well as confidence in making changes (Miller 2006; Miller and Rollnick 2002), can be very helpful here. Many people describe the process of talking with someone about their substance use very helpful, and often feel that it makes them more prepared to engage with treatment services.

- The goal of the discussion should be to *help her identify why treatment might be important for her* and to assess her confidence in following through.

- It is also important that a woman know *what treatment is available,* and that treatment does not necessarily involve residential treatment. It may be that outpatient counselling or a support group is most appropriate. There are many roads to change and recovery (see Moving Towards Safety: Using a Harm Reduction Framework section for more detail on this).

- Your hope, *empathy and belief that she can do well* are important to a woman's progress.

- Some women have been told, or feel, that they have *failed at treatment.* For the woman who has tried treatment in the past and feels that it did not work, it can be helpful to validate her experiences. Try to normalize the fact that recovery often includes relapses and that many people make many attempts to address their substance use before meeting their goals. Emphasize that there are different ways to get support and treatment that may suit her better. Help her to understand that there are different stages of change and explore with her whether she is at a different stage of change now than she may have been in the past.

Preparing yourself and your service for making referrals to treatment and supporting women's decision-making

- Build a relationship with your local detox and treatment services. Often it works to have a woman counsellor regularly visit your service, to consult with staff and have informal time with women[6].

- Find out how different services like referrals to be made.
  - Withdrawal management, daytox and stabilization groups–this usually requires only a phone call on the part of the service provider or woman herself. Be prepared to discuss her symptoms and needs.
  - Outpatient counselling–this usually involves a phone call on the part of the woman herself to make an appointment for outpatient services (you can offer to sit with her while she makes it).
  - Day and residential treatment—outpatient services usually act as gatekeepers for day and residential treatment, so you only have to know the number for the outpatient services in your community. If a referral to residential treatment is being made, you may have a role in helping the addiction counsellor and the woman get the paperwork done.

- Find out more about your local *Pregnancy Outreach Program.* You can do this using the website *www.bcapops.ca.* Perhaps arrange a visit to them to see what services they offer and build connections.

- It can be useful to have *pamphlets from alcohol and drug services* in your service to assist women in thinking about their service options. Have the treatment centers, like the Aurora Centre, bookmarked on your computer so women can see what they offer–see *www.bcwomens.ca/Services/HealthServices/AuroraCentre/default.htm.*

- It is also good to have other *resources* such as workbooks like the *Woman's Addiction Workbook* by Lisa Najavits accessible in your service for women to refer to. There is also a poster with a list of alternatives to using drugs that you may like to obtain and display (available for $15 through the Seeking Safety site: www.seekingsafety.org).

- Some women's services *provide space for meetings of 16-step groups* that help women make connections among the issues facing them and connections to services.

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6   We have included a handout in Appendix 3 called Making Connections: Women's Experience of Violence, Mental Health and Substance Use Problems for you to use with service providers from other agencies.

2.5.8 How Mental Health And Addictions Services Are Organized In BC
By Jill Cory

It may be helpful to understand the organization of mental health and substance use/addiction services regionally in order to build relationships with service providers and to be an effective advocate. In this section we outline the overall organizational structure and service responsibilities of various authorities and then provide contact information across the province.

There are three structures that have responsibilities for mental health and addictions services in BC.
- Ministry of Health, Mental Health and Addictions Branch
- Provincial Health Services Authority (PHSA) Mental Health and Addictions Services
- BC's five regional Health Authorities.

Ministry of Health, Mental Health and Addictions Branch
The Mental Health and Addictions Branch is a branch within the BC Ministry of Health. According to the BC Ministry of Health website, the Province of British Columbia envisions a comprehensive, integrated, evidence-based system of mental health and addictions services. These services focus on health promotion, prevention, treatment and recovery, and support individuals' and families' resiliency and self-care. BC has developed various strategies and initiatives to improve health outcomes for individuals with mental disorders and/or substance use disorders, their families and the communities in which they live. Provincial strategies and initiatives for depression, anxiety disorders, mental health literacy, and addictions can be located on this site.

The Mental Health and Addictions Branch has the following responsibilities:
- Providing leadership in provincial policy development and long-term planning for mental health and addictions services;
- Providing leadership in developing best practices for mental health and addictions services to meet diverse needs; and,
- Developing partnerships between government, health authorities, service providers and community organizations.

The recent alignment of addictions services with mental health services offers new opportunities for improving access and responsiveness.

The Provincial Health Services Authority (PHSA)
PHSA's primary role is to ensure that BC residents have access to a coordinated network of high-quality specialized health care services. PHSA operates eight agencies that provide province-wide health care services, including BC Mental Health and Addictions Services, BC Women's Hospital and Health Centre, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Centre for Disease Control, BC Cancer Agency, BC Provincial Renal Agency, BC Transplant Society. See *http://www.phsa.ca/AgenciesServices/default.htm*

BC Mental Health and Addiction Services (BCMHAS) provides a diverse range of specialized, "one-of-a-kind" tertiary-level mental health services to people across the province. The following is taken from www.bcmhas.ca:

Recognizing that people with mental health challenges may also have co-occurring issues with substance misuse, the assessment and treatment of addictions is an integral part of our programs, which comprise:
- Adult Psychiatry, Geriatric Psychiatry and Neuropsychiatry Services: Located at Riverview Hospital in Coquitlam, near Vancouver, these programs deliver highly specialized mental health services to the most challenging mentally ill adult patients in the province.

- Forensic Psychiatric Services: Located at the Forensic Psychiatric Hospital in Port Coquitlam near Vancouver, plus six regional clinics across BC, FPS provides court-related psychiatric assessment, treatment and community case management for adults with mental illness who are in conflict with the law.
- Child and Youth Mental Health Services: Located at BC Children's Hospital (BCCH) in Vancouver, these inpatient and outpatient programs provide a variety of specialized psychiatric assessment and treatment services for children, youth and their families from all regions of BC.
- Provincial Specialized Eating Disorders Program provides inpatient and outpatient assessment and treatment for BC youth and adults living with an eating disorder, located at BC Children's Hospital (for children and adolescents) and St. Paul's Hospital, Providence Health Care, Vancouver (for adults).

In addition to providing direct services, BCMHAS takes a provincial leadership role, working with an extensive network of community partners as a support and resource to service providers throughout BC. As well, the agency contributes significantly to research and knowledge exchange in the field of mental health.

Regional Health Authorities
The province-wide delivery of addictions and mental health services is provided through BC Health Authorities (see www.healthservices.gov.bc.ca/socsec/index.html). In developing this tool kit, we discovered that each health authority designs and delivers their mental health and addictions services differently. In some cases, gaining website access to information was quite straightforward, while on other health authority websites, no information was available.

Although visiting the websites is a useful learning exercise, as a front-line advocate working with a woman requiring mental health and/or addictions services, it will be more helpful for you to contact your health authority directly. Contact information for each authority is listed on their home page. Some things you might inquire about:
- Who is your health authority CEO?
- What is the organizational chart of your health authority? Do they have names of individuals or only positions attached to the organizational chart?
- Are mental health and addictions services located in the organizational chart?
- Who is the director or leader of mental health and addictions services at the regional level? At the community level? At the acute care or hospital level?
- What are the appropriate channels and procedures for accessing decision-makers within mental health and addictions?
- Is there a contact person within the mental health and addictions service in your community who could assist you in understanding how mental health and addictions services are delivered?
- What services are available at the regional, community and hospital (acute care) levels?
- How can you support a woman to access these services? (criteria, wait list, referrals, location, etc)

2.5.9 References, Resources And Further Reading

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Trainor, J, Pomeroy, E., Pape, B. 2004. 3rd ed. A Framework for Support. CMHA: Toronto, ON. Accessed at *http://www.cmha.ca/data/1/rec_docs/120_Framework3rdEd_Eng.pdf.*

Seeking Safety
www.seekingsafety.org
Excellent site for information about this model of integrated treatment for trauma and substance use by Lisa Najavits. Downloadable articles on a wide range of Seeking Safety applications, training opportunities and more.

Self-Help Resource Association
http://www.vcn.bc.ca/shra/

Canadian Mental Health Association, BC Division
www.cmha.bc.ca

Here to Help
www.heretohelp.bc.ca

Mental Health
www.mentalhealth.com

Canadian Health Network
www.canadian-health-network.ca

Mental Health Net
www.mentalhelp.net/poc/view_index.php?idx=home

Centre for Addiction and Mental Health
www.camh.net/

Mood Disorders Association
http://www.mdabc.net/

2.6 A Survivor's Story[1]

Laura[2] is a 31-year-old Aboriginal woman with two children, who accessed Community-Based Victim Services a number of times over the past few years for historical childhood abuse and relationship issues.

We had not heard from Laura in about a year and a half when she contacted us again. She seemed very disconnected and was suicidal. She told the Victim Service Worker that her children were in foster homes, that she had no food at home, that everyone on the reserve was talking about her and that she had been sexually assaulted.

Usually Laura was very expressive and emotional; at her next session she just sat there staring and unable to talk. Towards the end of the session she told me that she had been down at the river, and she had thoughts of jumping in. After her appointment, I took Laura to Supper Club with me. Supper Club is a community/mental health/social project and was a place she could get a meal and quietly be with other people. Then I took Laura to the transition house, where she was able to live for the next few weeks, until she felt safe enough to go home.

Since Laura had already reported the sexual assault to the RCMP and the circuit court wasn't sitting for another month, we didn't have to work on the practicalities of going to court immediately.

Laura began going to some of the transition house programs and ended up in a sexual abuse workshop presented for staff and community members. Laura went to the workshop because she wanted her kids back, and she wanted to heal. At the workshop she identified with the list of signs of abuse. She realized that she was abusing herself by punching herself, pulling her hair out in clumps and not eating. Laura was surprised because she didn't realize that the sexual assaults had affected her.

At the same time Laura was having appointments with a counsellor who worked for the Band's Wellness Program. He was against Laura reporting the sexual assault. He thought it would sidetrack her progress in the work that she was doing to get custody of her children. Specifically, he said reporting would "mess up the work that she was doing around parenting." She had been sexually assaulted approximately 20 times since age 16, and she thought reporting could help her. Laura argued with her counsellor and did report the sexual assault. The counsellor subsequently terminated his services to her.

Laura had been alone when she went to the police station. She had been "shut down" and felt very anxious. She didn't want anyone there with her, and she was stressed because she didn't know what the RCMP were going to ask her. All she knew about the sexual assault was that she had passed out; when she awoke in the morning her eyelids were taped shut and her shorts had been cut off of her.

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1   The survivor in this story chose to have a conversation with the worker about her experiences and have the worker submit her story on her behalf.

2   Name has been changed to protect her identity.

The preliminary trial was held in her community, in the basement of the band office. There was no privacy; the band office basement is one large room with access to the outside and to the offices upstairs. The court was set up at one end of the basement and areas for lawyers and clients to meet were at the other end. Individual community members and workers from the offices upstairs wandered in and out. There was no waiting area for victims or witnesses except the internal stairwell or outside. Community-Based Victim Services and the transition house workers were there to support and stand with Laura.

Laura waited for two years for the trial in Vancouver Supreme Court. By then Laura had gotten her children back and had another baby. It was challenging to find supportive people to care for her children while she spent five days in Vancouver for the trial, as she had no family support and felt she had no friends. Crown did pay for a friend to accompany her in order to assist in the care of her baby.

Connecting with Victim Services helped her to focus on what she needed to do now. She started by focusing on herself, her children, going to court, her use of marijuana, her anorexia and finally her relationships with men. Laura describes her life during these years as being "all over the place." The most challenging part for Laura was "loving myself, and trying not to feel dirty." She often felt despair and was suicidal. Laura felt she had no control and often became overwhelmed with all the healing that needed to take place.

As a client, Laura was very challenging as her needs were so great. Laura also had a number of service providers involved with her and they didn't all see Laura's issues the same way. With encouragement, Laura did stop looking to services, community members and family who were not able to support her. She began to access services and spend time with people who wanted to support her.

She has recently decided to leave this community and move closer to other family members who can support her in being a single parent to her children. Victim Services was always available for Laura in her process. What was most significant in our work together was how we shared, as a victim and a worker, having very little power. We both had very little information about when she would be called to court, when her appointments with Crown would be, etc. We would show up together and wait. Sometimes Victim Services was the only program that believed that Laura was not responsible for being sexually assaulted and that being sexually assaulted did affect all areas of her life.

3.1 The Importance of Safe Conversations: Identifying Risk and Resources

BY TESSA PARKES

3.1.1 Introduction

Assessing safety with respect to mental health and substance use involves having conversations with the women we work with about these aspects of their lives. The answers they give can be used to work collaboratively on assessing current and future risks to safety, health and wellbeing. Anti-violence services have tended to focus mainly on the risks of violence, for obvious reasons. However, risks to safety are compounded and affected by many issues connected to the abuser, service systems in place, the presence of children, and to the woman herself (Agar 2003).

A worker may feel overwhelmed with the task of assessing risk when a woman presents with a complex history, multiple intersecting issues and current challenges to her well being. The first step is to assess her risk from others. Following the completion of a safety from violence assessment, the worker will continue listening to the woman's story and observing cues in her presentation, which could lead to further safe conversations regarding risk. If a woman disclosed a mental health issue or a worker picked up cues that one might exist, then the worker will begin assessing for safety regarding mental health concerns. If there is mention of past suicidal behaviour or the worker senses a deep hopelessness in the woman, then assessment for current suicidal ideation or behaviour would be appropriate. Similarly if a worker noticed evidence of injury to the woman's body, it would be appropriate to inquire whether self harm was a strategy with which she managed her feelings or stress and proceed with a safety assessment regarding this behaviour if needed. If substance use is disclosed, then we inquire about risk and strategies already in place for mitigating that risk. Although this may at first seem overwhelming, it is often quite natural to explore how a woman is coping with any issue she has, to discover what her strengths and strategies are surrounding it, and where she may be at risk. The title of this section is the importance of safe conversations, because it is how we imagine this work proceeding. Over several conversations, safely, following the woman's narrative.

There are empirically based assessment tools that focus on the abuser's risk for escalating violence (BC Institute Against Family Violence 2006; Campbell, Sharps and Glass 2001 in Agar 2003), and while there is evidence for the validity of several of these safety/risk assessment tools, the literature on this subject is clear that assessment tools cannot replace the clinical judgment and intuition of a service provider, or a woman's perception of the danger in her situation (Agar 2003).

This section of the tool kit provides the rationale for having conversations with women about their mental health or substance use concerns. It also explores the cautions that have been expressed concerning the use of universal assessment or screening approaches to talking to women about these issues. By presenting different arguments, options and examples, it is our hope that services and individual workers will feel better informed to make decisions about how to individualize assessment/safety planning tools into approaches they are comfortable with.

While there are natural interconnections between substance use and mental health problems that allow this section to attend to both issues, there are also many differences between the two areas in terms of how safety assessment has been approached thus far in anti-violence services. Mental health assessments seem to be better incorporated into our work than assessments concerning substance use, at least at a basic level. Asking about substance use has been more contentious, in part due to some services denying access to women who use substances. This kit is strongly advocating the inclusion of the impacts of substance use in safety planning and in overall counselling work. For agencies that have policies regarding women being under the influence of drugs and alcohol, this policy will need to be explored and evaluated.

There are three main parts to this section of the tool kit: the first deals with general issues concerning assessment for mental health and substance use in anti-violence services; the second examines the importance of having safe conversations about substance use; and the third describes tools that can be used to ask women about their mental health and mental health problems.

The initial encounter is crucial in engaging a woman in services. The chief goal is to establish rapport: ask her what she needs and respect her answers. This may be as simple as providing reassurance that you will be there for her. Respect a woman's autonomy without judgment or argument.

3.1.2 Assessing Women For Substance Use And Mental Health Problems: The Debates

Routine assessment of mental health problems and/or substance use is a controversial issue in the anti-violence movement. Many anti-violence workers have a lack of trust in mental health and substance use services. Some advocates have expressed concern that conducting mental health assessments might alienate and further endanger abused women. They worry that assessments will lead to referrals to services that do not have an informed understanding of woman abuse in their medical or psychological assessments and interventions. Many in the movement view the mental health system as being pathologizing: by adding to the risks that abused women face (with diagnosis, medication, couples counselling, etc) and by failing to respond to the social underpinnings of abuse (Warshaw and Moroney 2002).

Defining our Terms: *Assessment* is the process of learning more about a woman and her situation in order to provide the most effective service we can. The process of *screening* is the questions we ask and conversations we have to determine whether a woman is eligible for our service.

In order for a woman to access mental health services, she needs a diagnosis; however, for an abused woman, just having a diagnosis may create a new danger. Psychiatric diagnoses are often used by batterers to "prove" that the violence is her fault, that she is "crazy," or that she is an unfit mother. Because both mental health problems and substance use are highly stigmatized, they are often used against women in child custody decisions by the legal and child welfare systems as well as by abusers (Warshaw and Moroney 2002). These are some of the reasons why some anti-violence workers choose not to complete formal assessments.

Overall, formal mental health assessment is not the norm in anti-violence services, since women are seeking services to address safety rather than their mental health or substance use concerns. But there are now many

working in anti-violence services who believe that substance use and mental health assessments can be very helpful as part of the work of helping women address the risks in their lives and increase their safety, support and general health and wellbeing. This view is connected to the belief that making substance use or mental health concerns visible should provide a woman with greater opportunities for more realistic and sensitive safety planning. If a woman has problems with substance use and is in a violent relationship she may be at risk of different or additional harms: physical, emotional, mental, financial and social. Discussing risks to safety can highlight areas of additional support she may require from your agency or from other agencies.

Assessment should not be used to exclude women from your service. It should be used to improve advocacy, risk assessment and safety planning.

One of the most important questions that need to be raised regarding safety assessment is: what is our purpose in discussing substance use and mental health concerns with women? Other key questions include:

- Why do we want to assess for substance use? For example, are we assessing with a view to excluding certain women?
- What are we going to do with the answers? How will they assist us to help her?
- Are these women the ones we find most challenging to work with?
- Are we using assessment to reduce our own anxiety or increase our own comfort?

Another important issue to address early on is how we act on the information we receive. Safety or risk assessments can become bureaucratic exercises that have little value in practice. We need to use this information to provide women with the best support we can, individualized to her particular circumstances and needs. Of course sometimes she may just need us to listen attentively and compassionately to her story.

One main reason for having conversations about substance use and mental health is because women with substance use problems (very dependent on use) or debilitating mental health problems may find some of the trauma processing elements of counselling too demanding. A woman may only be able to engage in stage one stabilization and safety work (see Haskell 2003; McEvoy and Ziegler 2006).

3.1.3 Creating Safety In Our Conversations About Substance Use

"The intervention is in the asking. When women are respectfully asked about both their use and their safety, they hear, even if they are not ready to listen or enact change immediately. Often women will later share comments such as, 'You know, when you said… it really made sense to me'" (Bland 2001).

Many of us are uncomfortable talking about substance use. This can be for a number of reasons: lack of training, feelings of incompetence, personal experiences or beliefs. We may also fear "opening up a can of worms," or making a woman uncomfortable or angry. Because violence against women and substance use frequently occur together, discussing substance use is important. We therefore need to do what we can to get to a place where we are comfortable in addressing these issues with women. According to Bland (2001), the first requirement of respectful conversations about substance use is an honest evaluation of our own attitudes and beliefs about substance use, abuse and addiction. Training can help, so can talking with those with more experience in this area, peer support and supervision, or doing some reflective work such as that included in this resource kit (see section on Trauma, Mental Health, Substance Use within an Anti-Oppression Perspective). These can all help us to move our practice forward. Other things can also get in the way such as the perceived lack of time, lack of trust in other service providers or a lack of knowledge of community resources.

Reflective Work

Draw up two lists of the hopes and fears you have about talking to women about their substance use. Now do one for talking to women about their mental health problems. How do the two lists compare? How many of these feelings get in the way of working alongside women on these issues? How may the hopes help your practice?

Discussing substance use must be done respectfully with a non-judgmental attitude. Whether you integrate questions about substance use in secondary intake forms, or use separate tools, women may well need to build up some trust with you before disclosing substance use or mental health problems: *information is unlikely to be given until it is perceived to be safe to do so.* It is therefore essential to establish a degree of rapport and trust with a woman before having these conversations. Additionally, careful consideration must be given to how information surrounding substance use is documented, particularly when using forms. It is recommended that agencies consult the Records Management Guidelines (2006) regarding intake forms and documentation when considering using any of the forms in Appendices 4, 6 and 7 in this kit. Many practitioners would advise not to ask questions about substance use in the initial encounter because of the danger of alienating women from your service (if she brings up the topic that is obviously different from you raising it).

If you decide not to have conversations about substance use at intake you may wish instead to be sensitive to any clues you may get that a woman has problems with her substance use. The following list is adapted from Getting Safe and Sober: Real Tools You Can Use by Alaska Network on Domestic Violence and Sexual Assault (2005) accessed at www.accessingsafety.org.

Cues indicative of substance misuse may include:
- The odour of alcohol on her breath
- Red eyes, pinpoint or dilated pupils
- Track marks on arms, hands or feet
- Inflamed, eroded nasal septum
- Rapid speech
- Difficulty tracking information
- Scratching and picking at arms or face during a visit
- Lethargy
- Nodding
- Cigarette burns (may also be indicative of violence or self harm)
- Prescription drug seeking behaviour
- Distorted perceptions

The reason for doing this is the evidence that shows that women who have these additional concerns are more at risk in many different ways and this should be an area of work you explore together at some stage.

Assessment should be ongoing. Conversations about substance use and mental health do not happen once. As safety and trust deepen, women will reveal aspects of their experience that they previously were uncomfortable sharing.

We need to be aware that certain language and approaches to asking questions about sensitive topics can trigger trauma symptoms and emotional flooding, and can be experienced as very disempowering. Try to balance key questions with reflective statements to clarify and support the information being given. Always tell the woman why the information you are asking for is important and how you hope disclosure will help her. Women should be in control of what information they give, and in how much detail, so let her know that she can refuse to answer any questions, or answer them at a later point.

> **W**orking collaboratively is the key. Without a respectful and collaborative approach underpinning our practice, all attempts to assess women for mental health or substance use problems risk further alienating women who are already vulnerable.

When opening conversations about substance use it can be helpful to lay some groundwork by using a general statement such as:

> *A lot of women find themselves increasing their substance use when in crisis. We have a commitment to working with women with substance use problems here, so please feel welcome to talk about your substance use if you have concerns. This will not jeopardize your access to services. In fact it will make it more possible for us to be truly helpful to you as you make your plans from here.*

Wherever possible, seek to lessen the stigma associated with talking about substance use and support the woman to understand the connections between her substance use and the other aspects of her life, including experiences of violence, trauma and abuse. Convey the message that substance use and violence can happen to anyone. As described in the section Trauma, Mental Health and Substance Use within an Anti-Oppression Framework, substance use can have various meanings for women with trauma histories, often complex and unique to an individual. We should avoid making assumptions and spend time discussing how she sees the connections. If a woman talks about having problems with her substance use it may be useful to refer her to addictions services for a more comprehensive assessment as well.

If there are specific negative consequences to disclosing use of substances within your service, it is vital that these are presented to women clearly in advance, including the reasons for these consequences. Your service should have policies and procedures to ensure that her disclosure is not going to put her at greater risk or jeopardize her safety further. Policies on MCFD involvement also need to be clear. Look for ways to discuss with women the ways in which their use of substances might cause difficulties for themselves, the service and others. Risky behaviour involving children, and children being put at risk, is one example where confidentiality of discussions about substance use would need to be broken and MCFD may need to be informed (please see the section Empowering Strategies When Children are at Risk). Stating your responsibilities around child protection to a woman early on in discussions is therefore very important.

Discussing substance use must be done respectfully with a non-judgmental attitude.

"**O**verall, 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. Some anti-violence services, such as Kaushee's Place in Whitehorse, have a policy of accompanying women who arrive there under the influence to detox services, and providing reassurance that the door will be open when a woman is able to return, when not under the influence" (Poole and the Coalescing on Women and Substance Use Virtual Community 2007).

Idea to try

If you are thinking of introducing a new assessment tool, try it out with interested participants who come to your service. What do they like or not like? How could the tool be more friendly or woman-centered? When would it be best used? How could additional safety be built in?

When discussing substance use, informational materials on the health impact of drugs and alcohol can be useful to both service providers and women accessing services. The Alberta Alcohol and Drug Abuse Commission's Effects Series (http://www.aadac.com/547_1430.asp) and the Prima Project website (http://www.addictionpregnancy.ca/substances/substances.html) are both useful tools for this work.

Remember—no one expects you to be a drug and alcohol expert—you just need to be able and willing to have conversations with women about their substance use and relate these conversations to the risks women are exposed to, their safety and ongoing physical, mental, emotional and spiritual needs.

Different organizations may require different assessments or assessment approaches, depending on the level of support provided for clients. The first thing you need to establish is what level of detail you need in order to deliver your service. It may be that you will not need to know about amounts and types of substance use. It may be more important to set the stage by asking questions such as:

- Are you interested in discussing your substance use?
- Are you interested in exploring the connections between substance use and violence and trauma?
- Do you think your substance use is an issue for your safety or the safety of others?
- Do you think your substance use will affect you in court?
- We have a policy that women not be using substances on the day of coming for counselling or a group—will this be difficult for you?

The questions we listed in the Broadening the Lens and Moving Towards Empowerment section are also very relevant to our work on opening the conversation on substance use:

- How does your substance use affect your life?
- Does your partner use your substance use to harm or try to control you in any way? You may wish to give examples and see if any of these are going on for a woman...

- Controlling supply? Forcing you to use with him? Telling you he is abusing you because of your drug use? Stopping you attending services/groups/appointments? Undermining your recovery efforts? Threatening to report you to child protection services? Threats to inform police or immigration services? How do you cope with this?
- Does your substance use affect your safety? How? How do you try to keep safe? What support could help you with this?
- What strategies do you use to manage any negative impact? How well do these work?
- Are there any changes you would like to make in your substance use? Do you have ideas about how you can make these changes? How confident are you in making these changes? Would you like some help with making these changes? What do you think would help?
- Would you like any information about substance use? What information would help you?
- Would you like to receive additional support for your mental health or substance use? What kind of help would you most like? Do you have any concerns about using a specialist service? Is there anything I can do?

If your service is aiming to do more developed work with women around their substance use issues then more detailed questions may be appropriate. Questions like these may be helpful:
- Have you ever thought you should cut down on your drinking or drug taking?
- Do you get annoyed when people criticize your use?
- In the morning do you ever wake and regret something you have done the night before?
- Do you think your drinking or drug use causes problems with your family/your work/your health, etc?
- What substances are used and how much is used?
- How are the substances used? Separately or with other substances?
- When are the substances used; e.g. what time of day, with whom? Describe a typical day.
- What makes you start or stop using? (The Stella Project 2004)

These questions may help you assess a woman's need for more detailed and comprehensive intervention from specialist services. If the woman wants to discuss her substance use in a more in depth way you could ask whether she would consider being referred to a drug and alcohol service. Once she is established with a worker there, you may want to check in with her whether she would like to continue accessing anti-violence services while she focuses more specifically on her substance use issues. At any time when you have referred a woman to another service, it is preferable with her permission to share her safety plan with the other worker.

> "Many anti-violence services work closely with substance use counselling services, inviting counsellors to make regular visits to establish relationships with women who may need support, and to demystify treatment and support options. Working together in this way also supports referrals to withdrawal management, harm reduction supports or addictions treatment, where necessary. Collaborative connections between service providers in anti-violence and substance use services models the connections that we hope that women will be able to make and draw upon" (Poole and the Coalescing on Women and Substance Use Virtual Community 2007).

We have included a standard intake form in Appendix 4 as an example to use to gather mental health and substance use information. The Records Management Guidelines (2006) recommend that a secondary intake form be utilized when a service provider is gathering more specialized and in-depth information in order to guide provision of appropriate service. Please refer to this resource for more guidance on documentation of sensitive information.

We have also included a handout in Appendix 5 called *Self-Report Checklist of Warning Signs: Do you have an alcohol or drug problem?* This is a checklist of some warning signs that may suggest an alcohol or other drug problem. It could be given to a woman to take away and consider before talking to her about her answers. It has been taken from a larger online resource called *What A Woman Should Know: Alcohol and Other Drugs* by the Alberta Alcohol and Drug Abuse Commission.

If your service requires more detailed substance use assessments, please see The Stella Project's *Domestic Violence, Drugs and Alcohol: Good Practice Guidelines* document (2004) for more information on possible assessment formats and questions (website is listed under resources at the end of this section).

3.1.4 Following Up: Ongoing Support Work With Women With Substance Use Concerns

Our work obviously does not end with having the initial conversations. This is the beginning of the work. Other sections of this resource tool kit discuss ways of working with women who have substance use concerns (see the sections Broadening the Lens and Moving Towards Empowerment, Moving Towards Safety: Using a Harm Reduction Framework, and Safety Planning with Women Using Substances). The following guidance aims to help you to work with a woman after she has described having problems with her substance use and has given you permission to work with her on this. It has been taken and adapted from the BCASVACP Best Practices Manual by McEvoy and Ziegler (2006). While it aims to support counsellors, it is relevant to all anti-violence workers who are undertaking more in-depth work with women clients around their substance use.

- Support harm reduction by encouraging other healthy behaviours, such as eating and sleeping well.
- Ask how the substance helps her.
- Acknowledge the client's need for self-soothing, which the substance might be meeting. Discuss alternative means of self-soothing and tolerating painful memories and encourage her to practice these methods. Ask her to describe situations in which she has been able to use alternative methods (see Appendices 14, 17 and 19).
- Never meet resistance head-on. Certain kinds of reactions are likely to exacerbate resistance, back the woman further into a corner and elicit anti-motivational statements from her. Unhelpful counsellor responses include:
    - Arguing, disagreeing, challenging
    - Judging, criticizing, blaming
    - Warning of negative consequences
    - Seeking to persuade with logic or evidence
    - Interpreting or analyzing the reasons for resistance
    - Confronting with authority
    - Using sarcasm

- Try making some of the following motivational statements to your client.
    - I assume from what you've talked about that you have some concerns or difficulties related to your substance use. Tell me about those . . .
    - Tell me a little about your substance use. What do you like using? What's positive about using for you? What are the downsides of using?
    - Tell me what you've noticed about your using. How has it changed over time? What things have you noticed that concern you or that you think might become problems?
    - What have other people told you about your using? What are other people worked up about?
    - What makes you think you might need to make a change in your use?

- You don't think that _____is harming you seriously now, and at the same time you are concerned that it might get out of hand for you later.
- You really enjoy_____ and would hate to give it up, and you can also see that it is causing problems for you, your family, etc.
- I appreciate you are hanging in there through this discussion, which must be hard to do.

- Encourage your client to try some of the following strategies to cut down her substance use:
  - Plan the substance use.
  - Set limits on the day, time and amount of use (e.g. only after 8:00 PM, only on weekends, etc.).
  - Try to have at least two substance-free days per week.
  - Delay the first use and each use after that.
  - Find something else to do as a distraction from wanting to use more.
  - Arrive at the dealer later than usual.
  - Leave the dealer earlier than usual.
  - Spend time with someone who will support your efforts to cut down.
  - Avoid situations where you are likely to use or where you use a lot.
  - Plan what days will be normal use and what days will be heavier use.
  - Prepare only a little of the substance at a time, even if you intend to use more.
  - Place the substance in a place that is hard to get to, or give it to someone who is supportive of your efforts to cut down.
  - Reduce your tolerance so you need less.
  - Keep a record of how much you are using and check whether you are meeting your goals.
  - Do not try to keep up to other people; go at your own pace.
  - Take only as much cash as you need when you go out, ensuring you have enough to get home.
  - Ask a support person to accompany you when you cash your social assistance cheques.
  - Leave your ATM card at home.

- Suggest the following strategies for dealing with cravings (see Appendices 14-16):
  - Identify when the craving starts; knowing what is going on is the first step in doing something about it.
  - Remind yourself that cravings are a normal part of cutting down and that they will pass with time; the more you give into cravings, the stronger they become.
  - Remember that cravings are like a hungry cat: the more you feed it the more it comes back. If you don't feed it, the cat eventually stops coming back.
  - Try to find something to distract you, even if this only delays you from using the substance.
  - Try to learn when you are most likely to crave the substance—for example, in certain situations, with particular people, when you feel a certain way—and plan how you will deal with each situation when it comes up.
  - Delay using for an hour or even five minutes. When the time is up, delay for another hour, then another hour and so on. It is easier to resist cravings for a manageable period of time than to try to stop forever.
  - Talk to someone supportive when you start to get cravings.
  - Do something relaxing and enjoyable instead, like having a bath or a shower, having a massage or using aromatherapy products to induce relaxation.
  - If you are able, go for a walk or a run or do some other physical exercise.
  - Visit friends who don't use the substance or won't while you are there.
  - Watch a video or go to a movie.
  - Listen to relaxation tapes.

- Reward your efforts to cut down, even if you ended up using more than you meant to. It takes time to make a change and being hard on yourself will make it more difficult to change your habits.
- Talk to friends who have been able to cut down their use and find out what worked for them.
- Talk to friends about how they enjoy themselves or relax without drugs to get some ideas that might work for you.

Some anti-violence agencies are experimenting with creating both formal and informal spaces where women can safely share their stories and learn about the connections between substance use, violence, poverty and other connecting factors. "Stitch and bitch" sessions at the Phoenix Transition House in Prince George are one example. Phoenix Transition House in Prince George, Haven Society in Nanaimo and Atira Women's Resource Society in the Vancouver area are offering meetings of the 16 Steps for Discovery and Empowerment groups (see Kasl 1995).

3.1.5 Why Talk About Mental Health Problems?

It is essential to gain as much information as possible about a woman's mental health and to do so in as empowering and as sensitive a way as possible. Mental health is an intrinsic aspect of our wellbeing and can easily become out of balance when we are stressed or in crisis.

Remember that mental health is on a continuum and is in a constant state of change.

There are many reasons why it is important to ask women about their mental health and their use of mental health services. One significant reason is that women who are living in violent relationships, who have trauma backgrounds, use substances or have mental health concerns, are at higher risk of being a danger to themselves than the general population. Suicide is a particular risk for this group of women, so we need to be asking the questions and being open to talking about self-harm and suicide in order to factor in these risks to safety, as well as looking at risks from others and other external risks.

Some anti-violence services will ask questions about mental health as part of their intake process, others as part of safety assessment or safety planning. It is advisable to ask women as soon as you can and while you are asking other questions, so that both questions about mental health and about substance use are normalized.

Doing a comprehensive assessment of a woman's mental health can help us to better direct our work with her. For example, we need to assess a woman's ability to be present with us to do advocacy, support and counselling work. Women with these intersecting concerns may benefit from support with education, advocacy, safety, stabilization, self-care, self-regulation, establishing boundaries and developing communication skills (McEvoy and Ziegler 2006). However, be wary about using blanket rules: some women with co-occurring problems may indeed be well suited for stage two trauma processing interventions within the STV Counselling framework. If in doubt, consult with your supervisor and ask the woman herself what she thinks, if this is appropriate. Your level of training, experience and access to good supervision will play a part in deciding whether this is an appropriate intervention.

> If a woman has mental health and/or significant substance use issues, be clear about the services you can offer without excluding her. Be aware that the effects of substances are similar to mental health symptoms and that mental health symptoms are often symptoms of living with violence. Do not attempt to be an expert—remember that the woman herself is the expert on her own situation and problems.

We also need to find out about any medications a woman is taking: prescribed drugs can have an impact on a woman's vulnerability and safety. The effects or side effects of medication can also be mistaken for effects of substance use or for mental health problems themselves.

If a woman has been diagnosed with a mental health problem it is likely that she will have been working with mental health professionals in the past and may still be. If this is the case, your agency should consider working closely with these agencies in an attempt to provide coordinated care and support Inter-agency coordination can be very beneficial when a woman has many complex problems and needs many different kinds of supports (see Treatment Issues with Mental Health and Substance Use Problems).

Intervention by mental health services is difficult for many women. A woman who has been abused may have been described as "crazy" by her abuser. A referral to mental health services may confirm this verbal abuse and deepen her sense of disempowerment and loss of self-esteem (Humphreys and Thiara 2003). Many women are terrified of the stigma of using mental health services within their own communities: this may be seen as worse than not getting any help.

Keep this in mind when making referrals to these services and try to make referrals to places that are more likely to see the interconnectedness of the violence and the mental health problems. Try working more closely with the services that do exist to help them become more aware of the interconnectedness of these issues (see handout we have created for use with other agencies and sectors: Making Connections: Women's Experience of Violence, Mental Health and Substance Use Problems in Appendix 3).

3.1.6 Asking About Mental Health Problems

At the stage of intake take into account how a woman is presenting to you—as anxious, over-excitable, depressed and withdrawn, tearful... Ask yourself what this behaviour and her emotional state may indicate. How does her emotional state help you to know what kind of approach you will take with her?

The following behaviours *may* indicate that a woman has mental health problems or is in mental distress:
- Being emotionally high or low in ways that seem out of context
- Being very nervous, panicky or distrustful/suspicious/hostile, beyond the circumstance
- Being hyperactive, unable to sit still or concentrate or very impulsive and quick to act
- Being very inactive, withdrawn and slowed down, slow speech and movement
- Lacking coherence or clarity in speech——bizarre statements, incoherent ideas or hallucinations
- Inappropriate facial expressions for the context or situation, unusual gestures or postures
- Speech very speeded up and thoughts seem to be jumbled up
- Inability to remember things, to use judgment or problem solve
- Disorientation or dissociation
- Dress and appearance out of character or unusual or very poor hygiene

These must be used with a good degree of caution however: it is not your job to diagnose the women you work with, or to be a mental health expert. Many of these behaviours are common in women who do not have mental health problems—they can be related purely to the crisis situation they are in, or due to trauma symptoms, sleep deprivation, the consequences of legal or illegal substance use, or some kinds of brain injuries or disabilities.

Possible questions to ask:
- Have you ever been given a mental health diagnosis by a qualified mental health professional?
- Have you ever been hospitalized for a mental health-related illness?
- Have you ever harmed yourself or thought about harming yourself?

Other questions that could be asked when completing a more detailed *mental health risk assessment* include:
- How would you describe your current emotional state/state of mind?
- Do you ever think about committing suicide? Have you tried in the past? Do you think about it now? How would you go about it? Have you planned to do it?
- Have you ever been violent? Where is your violence directed?
- Do you ever think that people are talking about you or conspiring against you? (The Stella Project 2004)

We have placed a Risk and Significance Summary in Appendix 6 that can be used to summarize the risks a woman is currently facing. It has been adapted from a similar form by Fisher and Choquette (1999). It asks you to assess:
1) How serious a risk to safety does the issue pose?
2) How important does the woman see each of these issues as being?

The mental health and substance use safety assessment form in Appendix 7 has been adapted from The Stella Project's *Domestic Violence, Drugs and Alcohol: Good Practice Guidelines (*2004) and details a number of significant areas to ask women about and write up brief comments about. Risk to others is rare in this population of women: they are much more likely to be a risk to themselves. However, in determining risk it is considered, by organizations such as The Stella Project, to be safer to cover all areas with a woman as a standard approach in a sensitive and non-judgmental way so that she can give her own account of her risks and dangers. If a worker or agency chose to utilize an assessment form in order to document risk and work towards safety, it is recommended that the form be brought into your work with a woman once a relationship has been established. Workers need to remember to limit their information gathering to what is relevant in order to provide effective service to the woman, in this case a careful assessment of her safety, and to keep any note taking brief and factual. Workers may want to review the *Records Management Guidelines* published by the BCASVACP and BCYSTH, 2006 for more information on case notes and gathering information at intake.

3.1.7 Self-Harm And Suicide: The Differences And The Inter-Relationship

The next two sections look at the risks of suicide and self-harm, as these are two of the main areas of concern for women with intersecting violence and mental health concerns and those that support them.

Assessment of a woman's mental health can help us to better direct our work with her.

Suicide and self-harm are fundamentally different and need to be treated this way by service providers. Self-harm is not suicidal behaviour. Self-harm is about trying to stay alive, despite the pain people are in. Many more people self-harm than kill themselves, and most people don't hurt themselves so badly as to risk their lives. Of those who do, suicide may not have been their intention; it is the feelings they want to wipe out (Understanding Self-Harm Booklet http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+self-harm.htm). It may be a way to reduce tension that could result in an actual suicide attempt. Self-harm is often the best way a person knows to self-soothe and represents the best attempt to create the least damage. Having said this, suicide and self-harm do have a relationship: a diminishing sense of self-worth, that may have been partially dealt with through self-harm, may culminate in suicide eventually (National Self Harm Network [NHSN] 2007). Evidence from recent UK research shows that people who self-harm are at greater risk of going on to attempt suicide (NSHN 2007). Following an act of self-harm, the rate of suicide increases to between 50-100 times the rate in the general population (Hawton et al 2003 in the NICE Guidelines 2004). This may be due to a common root cause behind both expressions of distress: the experience of trauma and abuse, particularly from childhood.

The Centre for Suicide Prevention has a helpful fact sheet that differentiates between suicide and self-harm. See http://www.suicideinfo.ca/csp/assets/alert43.pdf.

3.1.8 Self–Harm

"I was in pain and cut myself. I got labelled a manipulative borderline. But no one
ever asked me how I felt. Being called manipulative felt like when my mother used
to taunt me and called me a baby if I cried when she beat me" (Saakvitne et al 2002).

Self-harm consists of self-inflicted injuries such as cutting, burning, head banging, bleaching, cheek biting, hair pulling, picking at skin, genital mutilation, failure to seek medical care and hitting oneself, walls or other hard objects. Eating disorders are sometimes included in the definition as well. For women in violent relationships the risks of self-harm are high: one third of all women attending emergency departments for self-harm were experiencing violence in their relationships. Childhood experiences of physical and sexual abuse are also closely linked to self-harming behaviour in adulthood (Conterio and Favazza 1986).

Some of the reasons women give for self–harm:

- **To make me feel real —** *counteracts dissociation*
- **To punish me —** *addresses or temporarily lessens guilt or shame*
- **To stop me from feeling —** *safety tactic when strong feelings are too dangerous*

- **To mark my body** — *to show externally the hidden internal scars of trauma*
- **To let something bad out** — *symbolic way to try to get rid of pain, shame or things that were put in the body during abuse*
- **To remember** — *to repeat some aspect of an abuse experience as a way to remember without knowing*
- **To keep from hurting someone else** — *or to control my behaviour and my anger*
- **To communicate** — *to let someone know how bad my pain is*
- **To express anger indirectly** — *to punish someone without them getting angry at me* **(Inequality Agenda 2005)**

Other people may react to a woman who self-harms with disgust, confusion and avoidance. Fearing this kind of reaction, those who self-harm may refrain from seeking medical attention for their injuries to avoid judgmental reactions from medical staff. It is essential that you respond to women who self-harm with compassion rather than judgment.

It is therefore useful to directly ask about self-harm when working with women so that it becomes normalized. For example, you could say that it is a common coping mechanism among women survivors of violence and trauma and ask her if that has ever been her experience. In doing so, you are setting the frame for discussions when she is ready. It also communicates your familiarity with the problem and your willingness to have an open discussion when she is ready (McEvoy and Ziegler 2006).

What can be done to help?

During a recent study of people who have been able to stop self–abusing, the participants told us what helped them. Each participant had unique experiences but some very powerful lessons arise from the common themes identified.

Hope
Self–abusive behaviour is supported by an environment in which people feel worthless, powerless and hopeless. They react to these feelings by lapsing into increasingly self–abusive behaviours and in the process alienate family, friends and professionals. *Hope for improvement and for control over their lives is the ingredient identified as most important in reducing and eventually discontinuing self–abuse.*

Non–judgmental acceptance.
People who self–abuse are incredibly sensitive to the feelings of those around them. They are able to "pick up on" the frustration, anger and rejection of others. They expect this and are looking for it. People who will be able to help are those who are able to understand that self–abuse does not constitute a flaw of character but is a problem–solving device that soothes the painful feelings but makes life more difficult at the same time.

Continues on next page

Companions on the journey.

Although it may not always be possible to supply people who self-abuse with the companionship of others who have had, and have defeated, a problem with self-abuse, it is essential that they see helpers as companions on a difficult journey and not as authority figures with power to control their lives. It is equally crucial that helpers see themselves in the same way.

Understanding the behaviour.

Both helpers and clients need to accept the fact that self-abuse is soothing. It is also a way to maintain some sense of control over painful experiences and problems of living.

Learning healthy ways of self-soothing.

Since people who self-injure have never learned how to soothe themselves in healthy ways, they need to be shown that a variety of strategies can be used effectively. They need to be helped to create a list of such strategies to use when urges to self-abuse come. When first introduced to this concept they will often resist, saying, "that doesn't work". They need to be encouraged to keep trying, to work through several of their strategies before they "give up" and self-abuse.

Dealing with "trigger" events.

Raising to conscious awareness the cycle of response to a trigger event gives opportunities
- to discover what "triggers" the individual
- to challenge the cognitive distortions
- to identify and deal with the emotional reactions
- to formulate a variety of alternative strategies to deal with the trigger event
- to choose one of these alternatives and act on it.

Consistent use of this process will allow the person to feel more positive about their abilities to solve problems. They will feel stronger and more competent.

(Taken from: http://www.safeincanada.ca/)

For women with a history of trauma and/or current experiences of violence, assessment processes are needed to include her in (1) identifying specific circumstances that elicit potentially harmful behaviour, and (2) understanding what responses can help her de-escalate and feel safe (Carmen et al 1996). Because self-harm is a coping mechanism, the underlying causes will need to be identified before the self-harm behaviour can be successfully addressed. Focusing on the self-harm behaviour alone will not help a woman learn to cope with the underlying issues. Successful interventions help women learn new ways to express and articulate their emotions and needs, increase their tolerance for intense emotions, and recognize their triggers so that they can minimize, avoid or diffuse them.

Women should be in control of what information they give.

Safety assessment of self-harming behaviours
(material provided by Susan Armstrong)

Assessing whether someone is placing their life or physical safety at risk through their self-harm behaviour requires a detailed understanding of the actual method of harm. In order to assess level of risk adequately, one should know the following:

1. Does the individual harm alone or with others? The presence of others increases the risk.
2. Is the individual using alcohol or drugs before or while harming?
3. Is the individual sharing instruments with others while harming?
4. Is the self-harming planned or impulsive? Risk increases with greater impulsivity.
5. Is there suicidal intent attached to the harming behaviour?
6. Is the individual dissociated while harming? Risk increases, the higher the level of dissociation.
7. Does the individual have a pattern of self-harming that has been escalating?
8. How does the individual care for his/her wounds?

We have also included another assessment for self-harm in Appendix 8 that has been taken from the Best Practices Manual (McEvoy and Ziegler 2006). There is a lot of additional material on self-harm and ways of supporting women who self-harm in this resource. Please also see end of this section for a list of resources, including web resources, on self-harm.

3.1.9 Suicide: The Warning Signs

> *"I tried to take my life because he left me with no other way out" ("Jenny" in Humphreys and Thiara 2003).*

Thinking about killing oneself is an extreme solution to intolerable emotional pain and/or an intolerable situation. Survivors of childhood trauma experience high suicidal ideation.

For women in violent relationships the risks are high: abused women are five times more likely to attempt suicide than non-abused women (Barron 2004).

Mental health problems are the common thread in all groups with a high risk of suicide: Ninety percent of people who die by suicide were experiencing depression, an addiction or other diagnosable disorder when they took their lives (www.heretohelp.bc.ca). Ask your client questions about:

- Disrupted sleep patterns
- Lack of interest in usual activities
- Feelings of guilt, particularly survivor guilt
- Decreased energy, feeling like she is moving through molasses
- Inability to concentrate
- Disrupted eating patterns
- Suicidal thinking

A**ll highly suicidal clients need to be brought to the attention of your manager/supervisor. Follow your agency's policy and/or your community suicide protocol on limits to confidentiality when a client is a high risk for suicide. Inform your client of the requirement that you disclose her level of risk to another person. Discuss with her how this disclosure may best support her and involve her in the disclosure.**

Other warning signs your client may exhibit or tell you about include[1]:

- Hopelessness, helplessness, despair and loneliness
- Talking or writing about death, dying or suicide
- Rage, uncontrolled anger or thoughts of revenge
- Reckless or risky behaviour
- Feeling trapped, like there is no way out
- Increased substance use
- Telling you that she has obtained the means to hurt herself (e.g. has an extra refill of medication, has a knife)
- Withdrawal from friends, family and community
- Anxiety, agitation or panic
- Physical illness, chronic pain/disability or terminal illness
- Dramatic mood changes
- Writing a suicide note or completing a will
- Giving away prized possessions
- Feeling that she has no reason for living, no purpose in life
- No future orientation other than a preoccupation with death
- Comments such as: Sometimes I wonder if it's worth going on, All this won't matter soon anyway, I've made such a mess of things—my (partner/family/children) would be better off without me
- Sudden increase in energy and lifting of depression with no corresponding change in life circumstances: Your client could be relieved about having decided to kill herself. It may sound strange, but a person with depression may be most likely to attempt suicide just when he or she seems to have passed an episode's low point and be on the way to recovery. Experts believe there is an association between early recovery and increased likelihood of suicide. As depression begins to lift, a person's energy and planning capabilities may return before the suicidal thoughts disappear, enhancing the chances of an attempt.

You must directly ask your client specific questions, such as:

- Are you telling me that you are considering suicide?
- If yes, what method do you intend to use?
- Do you have access to the means? (e.g. stockpiling medications)
- How lethal is this method? (e.g. pills vs. a gun; means other than ingestion usually mean a higher level of lethality)
- Do you have a date, time and place in mind for your plan? (e.g. soon vs. sometime; using the garage or jumping off the balcony)

If you believe your client is contemplating suicide, consider using a suicidal assessment form (see the example of a Critical Incident Suicide form in Appendix 9). This will help you determine what level of care is needed.

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1   This list has been taken from the BCASVACP Best Practices Manual by McEvoy and Ziegler (2006).

Even a client with low risk requires some intervention. To fill out this chart, you will have to ask your client more questions, such as:

- Have you attempted suicide before (a high risk factor)?
- Has anyone in your family/friendship circle completed suicide?
- Have you recently experienced other losses? Is it an anniversary of a major loss?
- Has there been some other kind of precipitating crisis?
- Do you have a history of mental health concerns?[2]

We have also included guidance on preventing a suicide in Appendix 10. Many agencies have written protocols in place that workers are to follow when a client is suicidal. These protocols typically include a standardized assessment, critical incident form and referral protocol. Documentation of one's assessment of risk, what actions were taken to ensure safety, and if confidentiality was breached — to whom and whether the client was informed of the breach of confidentiality—is documented in the file. For more information on documentation when risk of suicide (or risk of harm to others) is present, consult the *Records Management Guidelines*, BCASVACP and BCYSTH, 2006.

Interventions with clients who have recently attempted suicide include the following:

- Remember that, for someone who has recently attempted suicide, there is a short window for you to intervene, since another, possibly more serious, attempt may follow. Ask your client to tell you, in her own words, what recently happened.
- Make definite plans for help, for additional referrals as necessary and for a future appointment (McEvoy and Ziegler 2006).

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The Stella Project. 2004. *Domestic violence, drugs and alcohol: Good practice guidelines.* Greater London Domestic Violence Project: London. Available at: *http://www.womensaid.org.uk/downloads/Tool kit%20Contents%20Pages.pdf*

Warshaw, C and Moroney, G. 2002. *Mental Health and Domestic Violence: Collaborative Initiatives, Service Models and Curricula.* Sept. 2002. The Domestic Violence and Mental Health Policy Initiative: Chicago. Accessed at *www.dvmhpi.org*

Selected Websites On Suicide

Alberta Alcohol and Drug Abuse Commission
www.aadac.com

Canadian Association for Suicide Prevention
www.suicideprevention.ca

Centre for Suicide Prevention
www.suicideinfo.ca

Children, Youth and Families Education and Research Network
www.cyfernet.org

Project Resilience
www.projectresilience.com

Resiliency In Action
www.resiliency.com

Suicide Prevention and Information Centre, UBC Mental Health Evaluation and Community Consultation Unit
www.mheccu.ubc.ca

Selected Resources On Self- Harm

Alderman, T. 1997. *The scarred soul: Understanding and ending self-inflicted violence.* Oakland: New Harbinger Publications. This self-help book for self-harmers explores the cycle of SIBs from various perspectives, including addiction and operant conditioning. Lots of exercises as well as discussions about alternatives to self-injury.

Burstow, B. 1992. *Radical feminist therapy: Working in the context of violence.* Toronto: Sage Books.

Connors, R. 2000. *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* Northvale, NJ: Jason Aronson Inc.

Connors, R. 1996. "Self-injury in trauma survivors: Functions and meanings." *American journal of orthopsychiatry* 66 (2): 197–216.

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Favazza, A. 1996. *Bodies under siege: Self-mutilation and body modification in culture and psychiatry*, 2d ed. Baltimore: Johns Hopkins University Press.

Herman, J. 1992. *Trauma and recovery.* New York: Basic Books.

Mazelis, R., ed. *The cutting edge: A newsletter for women living with self-inflicted violence.* The Sidran Institute. *www.cuttingedge@sidran.org.*

Miller, D. 1994. *Women who hurt themselves: A book of hope and understanding.* New York: Basic Books.

MIND UK. 2007. Self-Harm Information Factsheet. Available at *www.mind.org.uk /Information.*

National Self Harm Network (UK based) Available at *www.nshn.co.uk.*

Strong, M. 1998. *A bright red scream: Self-mutilation and the language of pain.* London: Penguin Books.

Trautmann, K. and R. Connors. 1994. *Understanding self-injury: A workbook for adults.* Pittsburgh: Pittsburgh Action Against Rape.

Turp, M. 2003. *Hidden self-harm: Narratives from psychotherapy.* London: Jessica Kingsley Publishers.

Self Abuse Finally Ends website with information and resources
http://www.safeincanada.ca/

www.nch.org/self-harm is a U.K. site that posts a guide to understanding and responding to self-injury called *Look beyond the Scars.*

www.palace.net/llama/psych/injury.html is a site that provides lots of information about self-harm. The site also hosts the "bodies under siege" e-mail support list.

A closer look at self harm factsheet from the Centre of Suicide Prevention:
http://www.suicideinfo.ca/csp/assets/alert43.pdf.

MIND UK. 2007. Self-Harm Information Factsheet. Available at www.mind.org.uk /Information

National Self Harm Network (UK based): www.nshn.co.uk

http://www.selfharm.net/: Describes itself as "The most comprehensive source of self-injury information on the web. Includes definitions, explanations of why, etiology and demographics."

3.2 Safety Planning with Survivors of Violence

BY TESSA PARKES

3.2.1 Introduction

When a woman makes contact with an anti-violence service and discloses that her partner or ex-partner is abusing her, we should consider her a potential homicide until we know otherwise. In this way we keep ourselves alert to potential risks, and engage in a risk assessment/safety planning process as a very first step of intervention. We start the safety planning by assessing the risk of violence and strategizing about what she and relevant services can do to address it.

In order to increase the effectiveness of the safety planning process, we then shift our lens to consider the impact of mental health issues on her safety. A worker may want to imagine that second level of inquiry as being a transparency that is laid on top of the initial assessment of risks and safety planning from violence, so that both layers are visible at the same time.

The third transparency to superimpose on the assessment is substance use—including licit and illicit—and its possible impacts on her safety. By addressing all three issues, we are addressing a wider range of potential risks to her safety.

3.2.2 What Is Safety Assessment And Safety Planning?

Helping a woman move towards safety is one of the key tasks that anti-violence services perform. Safety assessment and planning should be focused on reducing the risk of violence, not predicting violence. Women who live with violence have to continually evaluate their risk. Safety planning makes this ongoing process more conscious and proactive, with clear steps to take to stay safe.

> *"The woman herself is considered the best resource when safety planning and service providers should respect a woman's ability to choose the course of action best suited to her situation"* **(Agar 2003).**

In this chapter, we have incorporated information from the *Aid to Safety Assessment and Planning (ASAP) Manual* (BC Institute Against Family Violence [BCIFV] 2006; see end of section for ordering information). Workers would likely benefit from having their own copy to refer to. ASAP is based on the premise that *"a strategy for consistency in assessing the risk that the abuser poses and in planning for the woman's safety will increase women's safety overall."* The manual was developed with input from experts and practitioners working with women who have been abused, as well as an extensive literature review on violence risk assessment and victim safety planning.

ASAP provides a way to systematically consider many factors that affect a woman's safety, including the abuser, the woman's individual situation, her support network, and the level of the system's response. This systematic approach to safety assessment will guide the worker in assisting the woman to develop the best safety plan possible, uniquely tailored to her individual circumstances, needs and resources. As ASAP stresses, relationship abuse may have unique dynamics for a woman who is:

- Aboriginal
- An immigrant or refugee, especially where English is not her first language
- In a same sex relationship
- Affected by adult guardianship legislation
- Dependent on the abuser for care

ASAP suggests that anti-violence workers contact and seek the expertise of agencies that serve these diverse communities in these cases. The Manual itself provides some helpful material on safety assessment and planning with women in abusive same-sex relationships (ASAP Appendix A) and transgendered people in abusive relationships (ASAP Appendix B). ASAP Appendix C contains information about a range of relevant resources in BC.

3.2.3 Utilizing Safety Planning Tools

> Safety plans can assist to reduce danger. They cannot provide absolute safety (BCIFV).

There are a number of safety planning tools available to support our work with women. It is assumed that each anti-violence service has its own version of a safety assessment and plan. If you are looking for a good base for your work, we recommend using ASAP and the BCASVACP safety-planning outline reproduced in Appendix 11.

It is critical that documents like these are used in a way that acknowledges and builds on a woman's knowledge of her own unique situation. There are suggestions in this document that will work for some women, but might be unsafe or unrealistic for others. Equally important is the fact that a woman is likely doing things to keep herself/her children safe that are not included in this document.

Survivors and anti-violence workers with extensive experience in safety planning advise that documents listing options for safety planning SHOULD NOT be used as checklists to be reviewed with a survivor. They should be used as a tool to assist you, the anti-violence worker, to consider a broad range of possibilities in assisting a woman to plan for her safety.

Risks associated with the use of safety planning checklists include:
- Survivors may decide that the worker is the expert because they have all the answers, and as a result doubt their own instincts and experiences. This has proven to be very dangerous.
- Survivors may decide the worker is not likely to be helpful to them because their situation doesn't exactly fit into the checklist.
- Survivors may decide the worker is not aware of the context of their lives and therefore not credible.
- Survivors may feel that they are not being treated like a unique people with unique experiences and knowledge.

Tip: Keep the safety-planning checklist in your head as you engage in conversations with a woman about safety planning. Then refer back to the checklist to see if there is anything important that you have forgotten. This creates a more flexible and relational approach, while making sure everything important is considered and addressed.

Consider the following before you start a safety assessment and safety planning process with a woman:
- Discuss the purpose of safety assessment with the woman and see if she wishes to take part.
- Clarify with the woman that her choices are paramount. She is free to have a safety plan or not, or to act upon the safety plan or not.
- Provide emotional support during and after the safety assessment and planning process.
- Explain the confidentiality of the information and the legal limits to confidentiality.
- Collect only the information you need to plan for the woman's safety.
- Provide choices about whether the safety plan is written down, and, if the woman is taking it with her, how she will keep it safe from the abuser (BCIFV).

> A woman's strengths, opportunities and supports need to be identified with her, as well as her risks and vulnerabilities. As service providers we need to be able to allow women the space to learn from mistakes and go at their own pace in creating more safety in their lives.

3.2.4 Gathering The Information: Focusing On Abuser Factors And Safety Support Factors

ASAP suggests that safety assessments focus on two sets of factors: *abuser factors* and *safety support* factors. These factors are listed in Part Two of the ASAP Manual. We reproduce them here for your information and guidance, but refer you to the whole document, which provides much more important detail that will help you through the process.

Abuser Factors
- Abuser's violence
- Violent threats, ideation, intent
- Escalation of physical/sexual violence or threats
- Violations of civil and criminal court orders
- Negative attitudes
- Other criminality
- Response to shifts in power and control dynamics
- Employment or financial problems
- Substance use
- Mental health problems
- Other considerations, i.e. significant life changes, access to weapons, current emotional crisis, coping with chronic pain, trained in combat or military service, etc.

Helping a woman move towards safety is one of the key tasks that anti-violence services perform.

Safety Support factors
- Level of personal support
- Living situation
- Level of fear
- Barriers created by attitudes or beliefs
- Health impacts of the abuse
- Employment or financial concerns
- Child-related concerns
- Substance use
- Access to services
- Responsiveness of services
- Provision of information
- Coordination of services

Safety assessment involves identifying the presence and relevance of these factors. There is research evidence on the links between these factors and the increased risk of violence (this evidence is detailed in the ASAP Manual).

Review with the woman whether or not each of the factors listed above is present. If there is no information on a particular factor, think about ways to gather more information. Then consider the relevance of each of the factors and determine whether the factor decreases or increases a woman's safety.

Gather the information in a way that is respectful of a woman's Aboriginal identity, immigrant or refugee status, age, disability, geographic location, sexual orientation or gender identity.

As well as using the ASAP documentation, well-designed intake forms can provide us with an opportunity to gather relevant information to determine whether or not a woman is currently at risk from another person (or of harm to herself). Secondary intake forms may include information about a woman's physical, mental and emotional health (see The Importance of Safe Conversations: Identifying Risk and Resources and Appendices 3-9 for suggested intake forms and risk assessment tools). Remember that discussions about safety or risk assessment related to mental health and substance use may need to be left until a relationship has been established. Drawing out too much information early on in an intake process may be overwhelming for both the worker and the woman.

The Safety Planning Process

The safety assessment process is followed by an evaluation of a woman's options for managing her risk, culminating in the creation of a safety plan. Safety plans include strategies for escaping, avoiding and surviving the violence, and strategies for increasing the resources and support available to her (Agar2003). Assessment and planning should help women to identify patterns of escalation (internal factors as well as external ones) and early cues for escalation.

Questions To Ask Women

Are there ways that you know things are building up to violence? What are some of those signs?

The critical times when risk is heightened:
- Immediately following disclosure of the abuse to an outside party
- After the accused is interviewed by police
- When accused is released by police
- During charging process
- During plea discussion
- If stay of proceedings is entered
- Upon application for peace bond or other protection order
- Upon application to vary protection order conditions
- When accused is released on interim conditions
- When she initiates legal actions such as
  - Divorce
  - Custody or access
  - Property settlement
- When any papers are served, such as
  - Restraining Orders
  - Notification of Divorce or Separation Proceedings
- When she enters another relationship
- When the abuser loses control in other areas of their life

The processes of safety assessment and safety planning need to be dynamic, because risk factors will change. Women should be helped to evaluate changes in risk and modify their safety plans accordingly. Some questions that could be asked to help this process are:
- Has anything changed since we last spoke that might affect your safety?
- When you thought about the plan this past week, did you think that any parts of it might be difficult to put into action? Is this because something in your situation has changed?

Most experts suggest discussing with the woman the strategies that have been used in the past and what strategies she is currently using. Many also suggest discussing the strategies that agencies and services have used to try to support her. Ask her how helpful these have been and what barriers she experienced. The new safety plan that you develop together should build on these past and previous strategies.

Help the woman to develop strategies for the future based on the abuser factors, safety support factors and the protective measures available. These can include:
- Making a police report
- Obtaining a protection order
- Ensuring that supervision measures in place for the abuser are being implemented
- Interventions for the abuser, e.g. mandatory drug testing while on probation, removal of weapons, abusive partner's treatment, etc.
- Woman's physical security, e.g. cell phone, safe housing, alarm system, etc.
- Woman's well-being, e.g. accessing support network, meeting her health needs etc.

Discuss the documentation and use of the safety plan.

Priority Actions And Next Steps

This phase is an important next step and involves the following considerations:

- **Case prioritization**—note the level of effort or intervention that will be required to protect the safety of the woman or her children and other family members.
- **Serious physical harm**—note the risk that the abuser will engage in serious physical harm against the woman or her children and other family members.
- **Immediate action required**—note if immediate action is required.
- **Case review**—note when a safety plan should be scheduled for review. Set a date for a routine review and discuss with the woman what circumstances should trigger a special review. The safety plan should be revisited when there are important changes that might signal that the risk of an abuser's violence towards the woman is increasing.

Plans can be short-term or longer term and relate to, for example, a particular crisis situation, continuing to live with an abuser, leaving the abuser, continuing to have contact with an abuser while living apart, or a permanent separation (Davies et al 1998 in Agar 2003). For many abused women, the most dangerous period is in the 18 months after leaving the relationship. It is important for both the woman and the worker to revisit the safety plan regularly, even if there seems to be no immediate safety concern.

Studies demonstrate that family separation increases the risk of violence and homicide:

- In 1999, 40% of women who reported experiencing spousal assault by a past partner indicated that the violence occurred after the couple separated.
- A recent survey found that nearly one in five separated wives were assaulted while they were separated, and of those women, 35% reported that their husbands became more violent after the separation (Federal/Provincial/Territorial Ministers Responsible for the Status of Women 2002).
- Murder of a female partner is most likely to occur in the context of marital separation or divorce (Daly and Wilson 1999).
- Between 1974 and 2004, in Canada, the rate of spousal homicide against females has been three to five times higher than the rate of male spousal homicide. In half of all cases the woman was killed within two months of leaving the relationship (Department of Justice Canada).

Questions to Ask If Fear of Partner is Expressed and Only Contact is By Phone

- Are you in a safe place now?
- Are you injured in any way?
- Where is the person who hurt you now?
- Does the abuser have access to weapons?
- Can you tell me a little more about your concerns for your safety?
- Where are your children?

Improving Safety When A Woman Is Staying In An Abusive Relationship

If a woman chooses to stay with or continues to have contact with the abuser there are a number of ways that she can try to reduce harm to herself and any dependents. The suggestions below have been taken from the safety planning resource by Agar (2003).

- If she is separated but still in contact, then telephone contact is safer than face-to-face encounters.
- A woman may choose to leave temporarily if the violence escalates or to emphasize that she is serious about the violence ending.
- A woman should be supported to protect the privacy of her communication so that she can continue to safety plan without the abuser's knowledge (e.g. getting a cell phone and adding "password voice mail").
- Explore with a woman the ways that she can minimize injury and get help during an assault by thinking about her environment, support mechanisms and other factors.

Different Kinds Of Safety

External:

External threats to safety may include violence and abuse from others, situational factors such as the existence of firearms in the home, involvement in the drug trade or organized crime, and immediate high-risk living situations such as compromised housing, high risk child care circumstances and inadequate financial support (Fisher and Choquette 1999). Safety assessments should therefore also address social and environmental circumstances as well as interpersonal violence.

Internal:

Threats to safety may also come from internal factors such as suicide risk and severe depression, psychotic symptoms, disabling levels of anxiety and/or PTSD symptoms, severe eating problems, substance use and serious physical conditions that require immediate medical attention (e.g. diabetes, heart condition) (Fisher and Choquette 1999). Some of these internal factors will be created by behaviours of the woman.

Good safety planning requires a frank dialogue with women about their perceptions of their own risky behaviours. This should be tied to a discussion about the function of these behaviours; for example, how substance use or self-harm might assist in regulating her emotional state. Identifying the potential consequences is also vital, along with preventive strategies and crisis actions to take if the behaviours do occur. A more in-depth discussion on potential threats to safety from internal factors is contained in the next sections on safety planning with women who have mental health and/or substance use problems.

3.2.5 Extra Considerations For Safety Planning

Some women will require extra considerations and additions to their safety plans due to their culture, language, ability and/or other factors. For example, women who are disabled may be particularly at risk due to their increased physical reliance on an abuser (Nosek and Howland 1999 in Agar 2003). Particularly vulnerable groups are women who:
- Have a disability (physical or mental)
- Cannot effectively communicate in English
- Are living in isolated communities (geographical or social)
- Have insecure immigration status
- Do not work outside the home
- Are pregnant
- Are engaged in survival sex work

Ask women whether they have special needs for additional assistance that need to be accommodated in their safety plans. These may not be obvious to you as her supporter. Some examples are included below.

Disability: If I cannot leave my home because of disabilities I will contact

_____

to make arrangements for transport when my partner is not there.

Language: I do not feel comfortable speaking English so I will ask

_____

to translate or help me find someone to talk to in another language.

Taken from _Many Faces of Violence: Safety Plan_ at http://mfv.ca/.

> **R**isks will be present for women and children in violent relationships. Pets are also vulnerable to being harmed or killed and a plan for their safety, as well as the children's, can be highlighted in a safety assessment and plan.

Coordinating Our Work

The ideal situation in supporting women with their safety assessments and safety plans is for us to be working with other agencies to ensure women do not fall through the cracks, while also ensuring the confidentiality and safety of women's information and their right to privacy.

3.2.6 References, Resources And Further Reading

Agar, S. 2003. _Safety Planning with Abused Partners: A review and annotated bibliography_. Vancouver: BC Institute Against Family Violence. Available online at _www.bcifv.org/pubs/SafetyPlanning_Agar.pdf_.

BC Institute Against Family Violence. 2006. _Aid to Safety Assessment and Planning (ASAP) for Women who Experience Violence in Their Relationships._ Vancouver: Author. To order copies mail or fax: Centre for Leadership and Community Learning, Justice Institute of BC, 715 McBride Blvd., New Westminster, BC, V3L 5T4, Fax 604 528 5640 or email clcl_pr@jibc.ca .

Daly, M and Wilson, M. 1999. An Evolutionary Psychological Perspective on Homicide. In M. Dwayne Smith and M. A. Zahn, eds. _Homicide: A Sourcebook of Social Research_. Thousand Oaks, CA: Sage.

Davies, J., Lyon, E., and Monti-Catania, D. 1998. _Safety planning with battered women: Complex lives, difficult choices._ Thousand Oaks, CA: Sage Publications.

Department of Justice Canada. 2006. Spousal Abuse: A Fact Sheet. Available at _http://www.justice.gc.ca/en/ps/fm/spouseafs.html_.

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Fisher, P. and Choquette, E. 1999. _Women, trauma and serious mental illness: Intake, assessment, treatment planning and referral._ Vancouver: Spectrum Press.

Gondolf, E. W. 1998. *Assessing woman battering in mental health services.* Thousand Oaks, CA: Sage Publications.

Hart, B and Stuehling, J. 1992. *Personalized safety plan. Available* online at *www.mincava.umn.edu/hart/persona.htm*

Inequality Agenda. 2005. *Safe Conversations: Training Manual.* Faversham, UK: Author.

Jenkins, P. J and Davidson, B. P. 2001. *Stopping domestic violence: How a community can prevent spousal abuse.* New York: Plenum.

Many Faces of Violence: Safety Plan. Available at http://mfv.ca/.

McEvoy, M and Ziegler, M. 2006. *Best Practices Manual for Stopping the Violence Counselling Programs.* Vancouver: BCASVACP.

Mills, L. G. 1998. Systems strategies for working with battered mothers and their children. In *The Heart of Intimate Abuse: New interventions in child welfare, criminal justice and health settings.* (pp 120-146) New York: Springer Publishing Company.

Ministry of Attorney General. 1992. *Wife Assault: Violence against women in relationships: Victim service worker's handbook.* Victoria, BC: Author.

Seeking Safety
www.seekingsafety.org
Excellent site for information about this model of integrated treatment for trauma and substance use by Lisa Najavits. Downloadable articles on a wide range of Seeking Safety applications, about training opportunities and more. Useful materials on developing strategies for internal safety.

Stark, E and Flitcraft, A. 1996. *Women at risk: Domestic violence and women's health.* Thousand Oaks, CA: Sage Publications.

3.3 Safety Planning for Women With Mental Health Issues

By Tessa Parkes

3.3.1 Introduction

"He kept telling me I was the one who was insane, and that I was always going to be that way as long as I used the drugs. So it was my fault that I made him angry. When I would really get into the crack I would get to the point where I'd get suicidal. And then it was him not being able to cope with my mood changes and stuff like that"
(Woman survivor in Edmund and Bland 2006).

As described in other sections of this toolkit, mental health problems such as depression, suicide attempts and self harm are frequently symptoms of abuse and need to be addressed in safety planning alongside issues of substance use and violence against women. Sometimes the psychological impact of being abused can lead to the development of significant mental health problems that may interfere with a woman's decision making ability (Agar 2003). For women with trauma histories, the risk of developing mental health problems in response is heightened. Pre-existing mental health problems can also be exacerbated by abuse and violence, for example through having medication routines interfered with, increased stress, or being unable to maintain wellbeing through preventive activities and attending supportive appointments (Jenkins and Davidson 2001 in Agar 2003).

This section of the toolkit is focused on safety planning when mental health issues are present. It has been written to complement and be complemented by the section Safety Planning with Survivors of Violence. As stated earlier, workers are expected to start any safety planning process with one focused on violence and then to add the lens of mental health and substance use when applicable to ensure that all impacts to safety have been addressed.

3.3.2 Connecting The Experience Of Living With Violence And Mental Health Problems

When women in violent relationships have mental health problems, abusers may attempt to exploit the woman's vulnerability or limitations around her mental health problem. They may do this in the following ways:
- Humiliate her by telling people of her mental health diagnosis
- Minimize or deny abuse by telling her she is imagining it or hallucinating
- Threaten to have her institutionalized if she reports the abuse
- Prevent her from getting help for her symptoms
- Keep medications from her, give her too much medication, demand that she takes medication
- Take advantage of the changes in her symptoms and moods by, for example, deepening suicidal feelings by encouraging them
- Threaten to take her children away and tell child protection authorities or the court of her illness

- Give false information to medical and psychiatric professionals, resulting in wrongful diagnosis/commitment/medication
- Convince her that she doesn't deserve to be, or won't ever be, in another relationship because of her mental health problem/disability
- Claim that she is an unfit mother because of her mental health problem/disability
- Minimize her credibility to police or other concerned parties by playing into stereotypes that people with mental health problems/disabilities are not credible (www.accessingsafety.org).

There are obviously many implications in the above for safety assessment and safety planning with a woman. If any of these are being experienced by a woman they should be flagged in her safety plan with potential strategies that you both can think of that may work to keep her safe or safer. The strategies will need to be individualized and appropriate to the dynamics that are occurring.

There are also other factors that increase the risk for women who experience mental health problems: ones that are connected to wider societal views about people with these kinds of problems. The socialization of those with mental health problems to be compliant with people with more power than them can lead to additional dangers, for example. This is particularly likely for women who have been institutionalized for extensive periods of time, but even spending short amounts of time in hospital can have a detrimental effect on how we perceive our own authority and autonomous sense of self. In mental health services, the most important decisions concerning a woman's treatment will be made by professionals, including, for example, if a woman is safe to be discharged or what medication she should be on. Women with a history of psychiatric treatment, and in particular of institutionalization, may utilize compliance as a survival strategy. This way of being with professionals may extend to workers in the anti-violence field and also may be acted out in her intimate relationship.

Negative public attitudes about disabilities in general, and mental health problems specifically, make women vulnerable in a number of other ways. Sometimes women with mental health problems are viewed as attention seeking, out of touch with reality, lying and manipulative: by those in society at large and unfortunately sometimes by those who work in health and social services. Being labelled or diagnosed with mental health problems can have serious ramifications on her self-esteem and on issues such as child custody, her ability to access resources, to make a police report of violence and/or to be perceived by a court as a credible witness.

3.3.3 Managing Overwhelming Feelings: How Abused Women Cope

When considering women's safety and making connections between safety, trauma and mental health, it is important to revisit the ways that trauma from the past makes a woman more vulnerable to certain emotional and mental states. Consider this question: How do the women you work with manage powerful and overwhelming feelings like: rage, despair, neediness, hurt, disappointment and love? Some of the strategies you thought of may include:
- Switching off—dissociation
- Depression and blankness
- Self-harming
- Obsessive routines and rituals
- Food—over or under eating, vomiting
- Self-medicating with alcohol or drugs
- Anger—suppressed or explosive
- Frantic efforts to distract themselves—e.g. through talking
- Acts of rebellion—criminal activity (Inequality Agenda, 2005)

Women's symptoms and behaviours, such as the ones above, can be viewed as adaptive: as ways of coping. Instead of just focusing on or treating the symptoms it is important that we look at:

- How do these make sense for her?
- How do they help her?
- How can we help her make the changes she wants?
- What does she need in order to cope without these symptoms and behaviours?

Ways that women reduce risks to themselves include:

- Appearing or being compliant
- Concealing or blocking emotional expression
- Keeping others at a distance
- Adopting the abuser's way of describing the abuse
- Trying to help or fix the abuser
- Keeping quiet
- Maintaining loyalty to the abuser
- Avoiding tenderness (Inequality Agenda 2005)

Once the distress and the behaviours of women we find difficult or challenging are contextualized it becomes evident that they are adaptations closely linked to their struggle to survive. However, while these ways of coping may seem to work for a while, they may also create new dangers. For example, these coping strategies may work to further isolate and distance her from other safe people, or she may begin to think she is responsible for the violence, or they may lead to her avoiding seeking help.

Reflective Question

How can I support a woman in viewing her behaviours as safety enhancing and invite her to see potential future risks?

3.3.4 Identifying And Responding To Warning Signs, Cues And Triggers

The work by Lisa Najavits (2002) and Peter Levine (2005) can be very helpful in guiding our work in this area of trauma, survival and coping strategies. Their work describes many of the potential struggles for trauma survivors with just getting through ordinary life, coping with the past, and dealing with the often associated substance use and mental health consequences of the trauma. Their materials can be helpful to share with women who have had these experiences, to help them make sense of their own internal worlds and the reasons why they are caught in many traps of negative and stressful emotional and cognitive states. Cowichan Women Against Violence use some extracts from Peter Levine's work *Healing Trauma* (2005) and Lori Haskell's work *First Stage Trauma Treatment: A guide for mental health professionals working with women* (2003) to share with women trauma survivors. Many find the information incredibly useful and comforting as they realize they are not "crazy" after all and are not alone (Increasing Control and Dissociation and Self-awareness in Appendices 11 and 12 are extracts from Haskell's book).

Most of us get cues or warning signs that we are moving into distressed states and with experience we can learn to initiate some preventive strategies that can help us to stay more balanced and in control in these moments. This takes a lot of work and is not easy to do: it is much easier to keep going in our old circles or patterns. It is especially hard to do for those people who are recovering from trauma or who are living in fearful and unsafe situations. Some of the resources produced by the Victoria Women's Sexual Assault Centre

(VWSAC), and based in part on the Seeking Safety model by Najavits (2002), suggest the following ways of helping to keep safe and prevent relapse (this term is used mostly to indicate relapse into substance use but can be expended to include relapse into experiencing mental health symptoms) and emotional breakdown.

- Helping women to recognize the warning signs of building distress and the triggers to using substances or to being overcome by trauma/other mental health symptoms. Possible questions include: What signs appear when you are starting to show distress? What feelings make you overwhelmed and scared? What situations or people can make you feel anxious/distressed/ threatened/uneasy/in need of substances/like cutting yourself? The Relapse Prevention handout in Appendix 14 can help you to work through this systematically with a woman. This exploration can help women to decide on strategies to use before the situation builds up to crisis (see Key Points about Red and Green Flags and Signs of Danger versus Safety in Appendix 15, and Create a Safety Plan in Appendix 16).
- Staying safe internally and avoiding relapse involves identifying people, places, situations and feelings that can lead to distress and relapse and making choices about what different actions to take when faced with these triggers and challenges. Part of the work with women will be to help them to begin to detach from unsafe people and move towards safe positive people. It will also involve choosing safe positive activities to get involved with when feeling stressed or distressed to try to avert crisis (See Safe Coping Skills in Appendix 17). Generally this work will involve increasing the control a woman has in her day-to-day life so that she has more opportunity to stay away from her triggers or risky things, people and places (see Coping with Triggers in Appendix 18).
- Strategies to help with self-soothing when distressed, tools to manage stress such as relaxation techniques and ways of combating mean self-talk and responding to oneself with compassion rather than blame and guilt (for strategies you could share with women see http://www.dbtselfhelp.com/html/dt_handout_1.html or http://www.psyke.org/coping/self_soothing/).
- The importance of reaching out for help to safe others and the need to rehearse this because of women survivor's tendency to isolate themselves and hide away when things get tough, identifying key safe supportive people who can be available in times of stress/distress/crisis.
- Using techniques for detaching from physical pain, staying in the present and focused on the here and now, such as grounding (see Appendix 19, Using Grounding).
- It is also important for the woman to have a written safety plan for herself that includes these strategies and techniques (see Additions to Safety Plan for Women with Mental Health Concerns in Appendix 20).

3.3.5 Creating Safety And Containment
By Cathy Welch

Helping women to develop strategies for containment and internal safety is key in managing intense feelings and finding ways to stay present and grounded. These include techniques commonly used in the containment of traumatic memories, affect regulation, and creating safety through grounding. Like any new skill, practice is important. Learning new skills is one thing, being able to use those skills in times of intense arousal or when triggered is something else altogether. Practicing on a daily basis, in times of relative calm, may prove invaluable in times when stress levels rise. Helping a woman find ways to contain overwhelming emotions and to develop a sense of inner safety is important no matter what our work with her is. Even if our only involvement with her is to support her in going to court, providing her with containment and grounding skills can be essential in managing her anxiety levels, and thus her capacity to be present and effective in court.

Creating a sense of safety and containment involves three components:
- developing a container;
- developing a safe place or natural state of calmness; and
- grounding techniques.

Developing a Container

Building a container is often the first step in developing a sense of inner safety and control and often is used in closing down after an initial assessment, which may bring up strong emotion, trigger memories or open a woman up in the telling of her story or at the end of a session. A script to use with clients in developing a container can be found in Lori Haskell's book First Stage Trauma Treatment (2003). The development of a container is also essential in the effective management of strong emotions. A container can be any mental image of a container that a woman wants. It needs to be strong enough to hold all her disturbing images, thoughts, feelings, and sensations, have a lid, door etc. that can be locked down, and needs to have a "one-way valve" where new material can be put in without opening the whole container, and a "spigot" where material can be let out in small amounts when she is ready. A strategy that may be helpful is to ask clients to begin to practice using their container on a daily basis, starting by putting any unresolved material, images, emotions or thoughts in the container before going to sleep each night and again in the morning before they start their day (in case anything leaked out in the night). Remind them that they do not need to look at what goes into the container, as that can be re-traumatizing.

Developing a Sense of Safety or Inner Calmness

Again, there is a script for developing a safe place with clients in Lori Haskell's book. Helping women to develop a sense of internal safety, and to feel what that feels like in her body, is another key element in our work. Finding a safe place may be difficult for someone for whom no place was safe. If this is the case it may be useful to ask the client to describe an image that represents feelings of calmness and to focus on where she feels that in her body.

Grounding Techniques

Grounding techniques strive to reconnect us to the present, orient us to the here and now and connect us to our bodies and a sense of personal control. Grounding techniques use both the awareness of physical sensations and cognition. Some examples of sensory awareness include getting people to connect with the ground by placing both feet on the floor, feeling the chair they are sitting in, becoming aware of what that feels like, or trying to pay attention to and take in their surroundings. Examples of cognitive awareness include knowing where one is, what day it is, what season it is, and what is happening in the moment (Haskell, 2003; and see Using Grounding in Appendix 19).

Affect Management Techniques

Regulating the intensity of emotions requires skills in containment, modulating emotion, identifying feelings, and being mindful. Some strategies for modulating emotion include dimmer switch, remote control, videotape or audiotape, etc. For more information see Increasing Control Over Your Feelings Appendix 12. Teaching relaxation, breathing and mindfulness skills is also useful. As well, encouraging women to engage in regular exercise is important in building the capacity to regulate emotion.

One technique that is easy to learn is the Emotional Freedom Technique (EFT). This technique was developed by Gary Craig and more information can be accessed at www.emofree.com. EFT uses acupressure points on the head and upper chest to tap into the energy meridians of the body to release any blockages. Many women have found this to be very effective in dissipating strong emotions, negative self-talk, physical pain and numerous other disturbances. It is well worth checking out the website above and learning the technique to pass on to clients. There you will find a link to a free, downloadable manual that explains the process of EFT.

3.3.6 Safety Planning When Mental Health Issues Are Present

Having a mental health problem does not preclude a woman from making accurate assessments about her own risk. Agar (2003) suggests that a woman's mental health should only be considered a risk factor if she has problems that interfere with her ability to protect herself.

"Safety means different things to different people. You will need to discuss with your client what it means to her. Never assume it will match what you think. For example, to you, safety planning may mean giving up self-injuring behaviour, but to the client, safety may come from cutting because it helps avoid intolerable feelings and terrible memories. It is important to define safety together. What does safety mean to her? Has she ever felt safe?" (McEvoy and Ziegler 2006).

You and your client have different experiences around safety and this will affect your assessments of risk and danger, and of the necessary interventions. If a woman has never lived with safety then the concept of safety is obviously extremely difficult to engage in. It is only through incrementally moving towards safety that she can begin to discover what safety is.

So the goal of safety planning is to create more awareness for a woman and her supporters on the dynamics of her mental health. This can be done through sensitive discussion with a woman that identifies:

- what triggers intense and difficult feelings
- what makes her feel worse
- what helps
- who helps

This can be very helpful both for her and for other key supports in her life that she may like to share this information with. A preventive plan of action can then be put together which clearly indicates what the woman can do herself, when she gets warning signs, and who/what else in a woman's life, such as professionals and informal supports, can assist her. This would be particularly important if a woman is feeling suicidal.

Key supportive people in the woman's life need to be identified in a safety plan, people who she can go to or talk to if she should feel desperate and suicidal.

Emergency contact numbers for mental health or other support professionals need to be clearly marked in the safety plan. It would be important to consider who is available to the women during evenings, night time and early mornings as well as daytime hours because these are likely to be the times when she most needs help and when there are fewer supports available to her. Help her to also identify what action she will take to maintain her safety when she cannot locate a support person.

We need to remember to focus on strengths as well as vulnerabilities when discussing safety.

Support a woman to explore and recognize specific vulnerabilities such as her own triggers for becoming unwell or distressed (escalating violence at home, demands at work, problems with children, painful anniversaries, child custody issues; see Appendix 15, Signs of Danger versus Safety). Below is an additional script you could add to your safety-planning template that specifically addresses mental health issues.

If mental health issues occur alongside violence in my relationship with my partner, I can enhance my safety by doing some or all of the following:

I will remind myself that violence affects my stress levels and impairs my mental health so when I am in violent situations I need to be more watchful of my stress and mental health needs. I will ask for help from

_____

The following events almost always increase my stress and have a negative affect on my mental wellbeing

_____

The warning signs that I am getting stressed and moving into crisis are

_____

and this is what I will do in these situations to try to keep myself well/balanced and to try to keep myself safe

_____

If I feel myself moving into a crisis state I can

_____

I can also

_____

I can call _____ for support when I feel emotionally distressed

The following people/places/things can be unsafe for me

_____

To safeguard my children I might

_____

Other things I can do to help me feel stronger are

_____

If there are additional supports you require for your mental health or substance use problem such as numbers of supportive professionals or advocates or medication then make sure these are stored with other important documents and items that you can take with you in crisis situations when you need to leave your home quickly.

Keep an extra supply of medication alongside other critical items with a trusted friend or in a concealed place, easily accessible if you need to leave quickly.

Think about:
- Medications and prescriptions
- Information about services and benefits
- Names and phone numbers for case workers or other service providers that can help to coordinate services for you
- Health/life insurance papers
- Medical records

Please see Appendix 20 for a handout of this to share with women.

3.3.7 Safety Planning And Possible Impact of Medications

Women with mental health problems in violent relationships are highly likely to be taking prescribed medication and this therefore needs to be considered when assessing safety and safety planning.

Over-prescription of psychotropic drugs can provide problems for a woman's safety in a number of ways:
- Sometimes even moderate amounts of medication can make women feel sedated and lethargic and this can affect their safety, including making it harder to concentrate, make decisions, think quickly, or be aware of the escalation of violence.
- Abusers can deny women's access to medication or divert their medication for their own use.
- Women leaving abusive relationships may be unable to bring their medications with them, which can increase risk in some situations where regular medication is needed (to prevent very unpleasant side effects of other medications, for example).
- Medical emergencies can result in some situations.
- Mixing medications and other substances such as alcohol can also be dangerous (particularly in the case of barbiturates).

Help a woman explore the benefits and drawbacks to her medication use; for example, is she getting enough benefits from it to counterbalance the risks it may pose?

If a woman is only experiencing negative effects and is not aware of any positive effects then this needs to be raised with her physician or psychiatrist/mental health team: ideally you could facilitate this if she was happy for you to do so. Advocate for a review of the medication, citing safety as your main concern. You need to stress that a woman needs to still be able to act to protect herself and her dependents from harm despite having mental health needs. Be wary of coming across as purely anti-medication as this is unlikely to get a positive response. If you can clearly evidence your concerns and the impact of medication on her safety this should help mental health professionals and family physicians work with the woman to get a better balance.

3.3.8 The Mental Health Act And Nearest Relative

Under mental health legislation a nearest relative can be called upon to make decisions in a person's best interests if they are deemed to be lacking capacity due to mental impairment. There are obvious dangers for a woman in having her abusive partner act as nearest relative. Here are some suggestions that you can support the woman with:
- Help her to tell her mental health support staff about the violence she is experiencing at home so they can ensure they do not compromise her safety by dealing with the violent partner when she is experiencing mental distress/health problems.
- Help her to choose a trusted and safe member of the family to be her nearest relative so that a violent partner does not assume that role.

- Support the woman to ask staff to place a note on her file at the front stating that she should always be seen alone. This should be in all medical and health environments, not just mental health.
- See Representation Act Agreement section for further strategies that could be used.

There are more specific vulnerabilities and risks that can be associated with different kinds of mental health distress and some of these are mentioned below. We have suggested some actions you can consider undertaking with women to build safety and decrease risk. You may want to add to these from your own experience.

3.3.9 Post-Traumatic Stress Disorder

When someone is a trauma survivor they can suffer from hyper-arousal, which can impact on safety on a number of levels. Hyper-arousal can quickly drain a person's physical and emotional resources, interfere with sleep, impair concentration and affect mood. A person may become easily distracted or have difficulty remembering, especially when under stress. There are dangers of over-reacting or under-reacting to current situations. Helping a woman to reduce her levels of stress wherever possible or manage it more effectively may help to improve concentration and memory to help with safety planning activities. Safety planning needs to take into consideration what impact the trauma symptoms have on a woman's ability to assess and respond to risks and dangers and be creative in thinking about ways of strengthening her response.

3.3.10 Self-Harming Behaviour

Some of the hardest challenges emerge around the issue of self-harm. When a woman self harms, particularly when she uses severe methods that inflict considerable physical harm to herself, many of us want to take control and move to action, including making the woman stop self-injuring. Remember that many dangerous behaviours (cutting, substance use) represent desperate attempts by women to manage or avoid terrible pain. Safety is as much a subjective experience as an objective one. When we ask women to stop these behaviours we may be asking them to tolerate intolerable feelings, be swamped with terrible memories and experience intense physical and emotional pain. That does not feel like safety. We must therefore continue to work in partnership, managing our own emotions constructively, even in very challenging circumstances, in order to allow a woman as much control as possible.

Self-harm is dealt with in detail in the section The Importance of Safe Conversation: Identifying Risk and Resources, and Appendices 7 and 8 have useful assessment tools. As with suicide, risks due to self-harm need to be explored during a general safety assessment, or a specific self-harm assessment (see Appendices 7 and 8), undertaken in partnership with the woman. Adopting a harm reduction approach can be effective as a woman moves towards safer methods of self-harm. If a woman is severely self-harming it is likely that we will need to make referrals to specialist mental health services and be working with these other agencies. It is always best practice to discuss any referral processes with the client and invite her active collaboration.

> It is important to differentiate life-threatening behaviour from other behaviours that make us very uncomfortable but that are not life threatening.

Sometimes, usually only in life threatening situations, you will need to act to protect the client from herself and intervene without her collaboration. These will be unusual situations and will need to be done with the clear support and guidance of management in your service and probably with other agencies. Even in these situations a respectful, sensitive, caring and non-judgmental approach is essential.

3.3.11 Suicide

Suicide is also dealt with in *The Importance of Safe Conversations: Identifying Risk and Resources.* If suicide is a threat then this needs to be explored as part of a safety assessment, or a specific suicidal assessment (see Suicide Critical Incident form in Appendix 9 and information on preventing a suicide attempt in Appendix 10)

3.3.12 Depression and Blankness

According to a study by Golding (1999 in Humphreys and Thiara 2003) the average prevalence rate for depression in women experiencing violence from an intimate partner was 47.6%. Given how common depression is in the women we will be working with, we need to expect some of these features below to be present, rather than seeing them as unusual ways of being. These are some of the behaviours that a woman may present if she is depressed:

- Slowed up in movement and speech and thought
- Hopeless about life in general
- Very low self-esteem
- Low motivation or no motivation
- Inertia and withdrawal
- No reasons to think life could be better
- Poor sleep
- Poor eating
- Things that used to give pleasure no longer do

Reflective Question

Have you witnessed some of these behaviours affecting a woman's safety? If so, how?

3.3.13 Psychosis: Commentary And Approaches To Help Women

"I need someone who could just be there— non-judgmental, solid, not trying to force me to do this or that, just being with me and helping me to make sense of some very frightening, but also very beautiful and visionary experiences."
"The problem is not so much the voices as the inability to cope with them."
(From materials on www.mind.org.uk).

One of the most challenging areas of our work is how to support a woman's safety when she is in and out of reality. Some signs that a woman may be experiencing a psychotic state of mind may be:

- Withdrawal and loss of interest in the external world
- Loss of energy and motivation
- Problems with memory and concentration
- Deteriorating ability to manage work, study or family life
- Lack of attention to personal hygiene
- Confused speech or difficulty communicating
- Lack of emotional response or inappropriate emotions
- General suspiciousness
- Sleep or appetite disturbances
- Unusual behaviours

Any of these may also be due to experiencing violence in intimate relationships. Even some of the more unusual experiences such as hearing voices can be surprisingly common in the general population. A large number of people with no other mental health issues have heard voices in the normal course of life, particularly during periods of stress or loss, and many also hold beliefs that others would consider unusual.

Psychosis is usually only diagnosed if a person experiences distress along with their voices or experiences the voices telling them to do things that they wouldn't ordinarily do. Some people take voices in their stride and others feel overwhelmed by them. Some people experience their voices as benign and helpful: as guiding them in life. Others experience them as hostile and nasty where the voices are belittling and ridiculing them. The most distressing voices tend to be those that are punishing and controlling of a person, even instructing them to harm themselves and others. Not everyone's voices have this element but voices can change and become more hostile over time. Some delusional ideas can be extremely frightening too, especially if they involve paranoid ideas.

For someone experiencing voices or other forms of hallucinations, they are very real to them. Someone who is experiencing psychosis may be terrified of what is happening to her or she may have grandiose feelings about it, like "I'm going to save the world from evil." It is important to know how the woman herself perceives the voices.

Having someone who a woman can trust and talk to, who will not judge her, will be critical to aiding her stability and recovery. Empathy— as always— is key. A trusting collaborative relationship is the main ingredient of helping women with psychosis. Don't underestimate the power of this.

The following points may be helpful for you to keep in mind when working with women who are experiencing psychosis:

- Some schools of thought suggest that the most helpful thing for a person with psychosis is for someone else to accept their reality and assist them to cope and live with their beliefs. Avoid getting into situations of either confirming or denying a woman's specific experiences or beliefs— focus on a full acceptance of the experiences as real for the woman herself (see www.intervoiceonline.org for more information on this).

- Normalize and validate her experiences wherever possible. Acknowledge it when you can see truth in what a woman says. The following statements may be helpful:
  - Many people would feel very similar in your situation.
  - It is very common to have the experiences you are having. Some people find it helpful to on practical details of safety like getting food, shelter etc. Do you think this may help you?
  - It is common to feel very threatened and unsafe around others when you live in violent situations.
  - That must feel terrifying. How are you managing to cope?
  - I can see that you are trying to cope with so many demands on you. No wonder you are feeling so overwhelmed and upset.

- Find out what the voices, and other experiences like delusions, mean to her. What role are they playing in her life at this moment? What explanations can she give for their presence in her life? What are they about for her? Provide opportunities for women to talk and reflect on their experiences in a calm, supportive and non-judgmental atmosphere. Provide lots of emotional support.

- Acknowledging the resultant emotions is also critical, even if it is not possible to explore the meaning of the experiences. Is she angry, sad, resentful, defiant, scared? This can be done even when a woman

is actively in a psychotic space. It may become clear that there is a meaningful connection to explore between a woman's personal history, her current situation and the voices or delusional ideas.

- Help the woman to develop strategies to reduce her fear, and to increase her coping and ability to problem solve. Help her to develop strategies to improve her safe relationships and her quality of life. Stay focused on what, when, where, with whom. Where is she going to sleep tonight? Is there a friend she feels safe with? Are there shelter staff she feels safe with? If she feels she is being followed, who does she feel safe to be with right now? Let her know you never want her to be hurt.

> When a woman is experiencing an alternate reality, the most important action a worker can undertake to support safety is to bring her back to NOW, if at all possible. Invite the woman to focus on practical details that will increase her chances of safety.

- Help the woman focus on her basic needs. Cycling through psychosis is tough and can often lead to time on the street, where one's safety is highly compromised. Ask about eating, shelter, clothing, access to medications etc.

- Many people who hear challenging voices have found that a turning point in learning to cope with the experience has been in finding different ways of talking with and understanding their voices. An approach based on this idea (see Corstens and May 2007) suggests that learning to understand the motives of the voices and trying different ways of talking with them can help the relationship to change between the voice hearer and the voices. This approach is based on techniques derived from various psychological traditions such as Transactional Analysis and Psychodrama. These are not approaches that mainstream psychiatry would adhere to but many consumers/survivors welcome the practical and validating nature of them.

- Support workers usually recommend plenty of sleep, exercise, a nutritious diet, a social support network, positive family connections, meaningful work and structured days.

- Regular appointments with a mental health worker can also be very helpful (provided they are able and willing to work with the interconnections between a woman's mental health and her life situation).

- Help her to make informed treatment decisions if she uses mental health services (see Broadening the Lens and Moving towards Empowerment).

- Discuss her medication: staying on medication over a long term can be challenging if there are serious side effects. Staying on medication during an episode of psychosis is particularly challenging and coming off medication abruptly brings on other complications. If a woman decides to stop taking medication, it is helpful to ask questions that assist her in connecting to the possible outcomes. What has happened in the past when you came off of medication? Did you stay safe? Did you end up in the hospital? Did you feel better? You may find that working with a harm reduction approach to staying on medication is helpful.

- Help her to regain confidence: many women feel ashamed by their psychosis, have low self-esteem and feel powerless.

- Early interventions are considered to be very important in terms of preventing a deterioration of mental wellbeing. With this in mind, help a woman to learn the early warning signs of an episode of crisis. Create a Ulysses Agreement (see section on the Representation Agreement Act, Ulysses Agreements and Advance Directives for more information) for action to take if a woman becomes unwell, with a group of safe others committed to supporting the woman.

- Help her to learn from her own body/mind/spirit what helps her to stay balanced and well. Help her to explore what her ideas of healthy choices are, and how she can put these into place for herself. Help her to think through what a balanced life is for her, in terms of her mental and emotional wellbeing.

- Explore together some relaxation tools that a woman is comfortable with and can easily put into practice on a regular basis— yoga, massage, aromatherapy or reflexology can be helpful for many women but this needs to be checked out, as some, especially ones involving physical touch, may feel too intense and overwhelming for some women who are in the midst of a psychotic episode.

- Local self-help groups can be very helpful to women who have these experiences— explore whether there are support or self-help groups in your local area for women with similar experiences. What other supportive or peer resources are there locally that may help her?

- Cognitive therapy helps to focus on the links between thoughts, feelings and actions and can help a person to put in practice strategies to cope with specific symptoms; consider making a referral for this type of therapy if the woman is interested and able to manage this level of insight-based work.

- Be hopeful and optimistic in your work with her.

3.3.14 Safety Planning With Women Who Are Highly Dissociative
BY MAGGIE ZIEGLER

What Is Dissociation?
Dissociation is the capacity to compartmentalize different aspects of experience such as memory, feelings and thoughts. Survivors of abuse and violence often suffer from some degree of dissociation. Dissociation ranges from mild daydreaming or fantasizing about something to complicated divisions within the self. In mild dissociation there is awareness of wandering off and returning, but in more severe forms awareness is compromised or entirely lacking.

What Are Safety Considerations Specific To Dissociation?
1. All of the safety planning and safety increasing activities described in this tool kit are of great benefit to women with dissociative tendencies. In particular, the container activities (see above) assist women to make their internal process more conscious and the grounding activities (see Appendix 19) support women to pay attention to what is happening in the here and now. Consciousness and grounding enhance safety.

2. It is important to ascertain a woman's ability to hear and retain information. There is no point creating a safety plan she is not going to remember or doesn't understand.
- Encourage women to take notes while discussing safety. Unless there is an issue of literacy or some other reason why she cannot write, writing is a physical act that enhances memory.
- Don't let your own urgency about her situation lead you to cover too much information or make a safety plan too quickly. Leave time for integration.

- Identify her capacity to hear and integrate information through questions such as:
    - This is a lot of information. Can you tell me what stands out for you?
    - Would it be helpful for you to write this down?
    - Let's review this safety plan before you leave. Why don't you share with me your sense of what you've agreed to? Let's go over the notes you took.
    - Where will you keep these notes and what would help you remember where they are?

3. Practice building safety in the relationship between you and the woman. Dissociation often involves a lack of awareness of shifts in moods or states. A woman might be engaged in conversation and then seems to drift off, but she might not be conscious of doing so. If she is aware of the shift, she might not know why she suddenly spaced out of what she was feeling and experiencing at that moment. This has implications for safety in the relationship and also for safety planning. Helping her track shifts in attentiveness and awareness is important. It may be helpful to go over a handout that delineates the differences between dissociation and self awareness (see Appendix 13). In order to create safety in the conversation, pay attention when her attention wanders.

- Ask questions that encourage curiosity. These provide information about what is happening between you as well as how she dissociates. She might be feeling unsafe with you for some reason, or on information overload.
    - I noticed you were staring out the window. What was happening just then?
    - Was there anything I said or did that caused you to go somewhere else?
    - How do you feel about how our conversation has been going?
    - What would help you to stay present?
    - What do you need from me? What could I do differently?
    - Is this what you do in your life when things are difficult or dangerous?

4. Focus on increasing her ability to follow through on the safety plan.
- Ask questions that help increase her awareness of the gap between something being wrong and mentally accessing her safety plan. Conversation around the following questions leads to more usable plans.
    - Do you think you will remember this safety plan when you need it?
    - What would help you remember?
    - Have you had experiences in the past when you've managed unsafe situations successfully? How did you do that? What made it possible to do that? What would make it possible to do that again?
- Make sure to follow up on how successful the woman was at implementing her safety plan. Review together what happened and track how well she was able to access the safety plans and the blocks to doing so. This will lead to a revised plan.
- Be patient. The goal is for the woman to increase her ability to stay safe, both externally and within herself. If you view this as a process you will both be less frustrated. Appreciate small successes and take "failures" in safety as learning opportunities. The more dissociated a woman is, the more complex this process becomes. If you ignore the obstacles, blocks, or the aspects of self that may not be interested in safety, you won't get very far. Contracts are not always helpful as they can lead to shameful feelings about "not doing it right."

5. One of the most helpful skills in increasing safety is mindfulness in the present moment. It is often at the moment of danger that dissociation occurs. This is a learned defence but the woman lacks the ability to protect herself in a dissociated state because she is not attuned to the present moment. She becomes more vulnerable.

Staying in the present moment means observing alertly what is going on internally and externally without being trapped in what is happening. This reduces dissociation. The woman sees that a flashback is a flashback —she knows she is simply remembering the past and not reliving it. For example, the peculiar man on the street is not the man who raped her and she knows how to act to maximize her safety.

The following guidelines for mindfulness are adapted from Marsha Linehan's *Skills Training Manual for Treating Borderline Personality Disorder* (1993). Consider taking training in mindfulness in order to use this with women.

- Observe your experience by noticing everything carefully. Practice not reacting to situations, or the feelings or thoughts that you observe in yourself. Stay alert to all of your thoughts, feelings and experiences and notice them with all your senses.
- Describe your experience in words. Name feelings as feelings, thoughts as thoughts, behaviours as behaviours.
- Participate by allowing yourself to become involved with the present moment. This allows access to intuitive knowledge. Practice implementing your safety plan and skills that change harmful situations.
- Accept yourself and your situation as they are.

3.3.15 Wider Supports That Can Promote Women's Safety

Ulysses Agreements
As described in another section of this tool kit (The Representation Agreement Act, Ulysses Agreements and Advance Directives), Ulysses Agreements or crisis plans are a way of putting plans in place before a crisis or a period of mental ill-health occurs, and these are one of the best ways of informing others (family, friends and professionals) of a woman's wishes if or when she becomes distressed or unwell. A woman can make it clear what triggers a breakdown in her mental wellbeing and signs of increased mental distress. She can describe what helps her in these situations and whom she would like to help her. This open communication and planning can help others to be in a position to help a woman if/when she becomes unable to manage her affairs. Plans for the safety and wellbeing of children can be made using these agreements too. Mental ill-health can be used by partners to attempt to get custody of children when a woman is hospitalized, so advance planning, and informing professionals of the risks to children from violent partners, can be important strategies to keep children safe.

Interagency Coordination
One of the best ways to more generally support women with mental health problems who experience violence is to build relationships with mental health services and professionals who have a sensitive and informed perspective on the interconnectedness of these issues. Having trusting and respectful relationships with key professionals in other agencies can help to break down the barriers between anti-violence and mental health agencies and this will benefit women who have intersecting concerns. This issue is dealt with more extensively in the section Advocating for Women's Safety.

Address Community And Neighbourhood Safety
Women with mental health problems are more at risk of being victimized in the community, so time should be spent exploring these risks, particularly if the woman puts herself in risky situations such as using substances or being engaged in street sex work. Personal and neighbourhood safety techniques can be thought through in advance in safety planning discussions. Helping a woman to recognize sexual harassment and discourage unwanted advances, providing sexual assault awareness and prevention and assertiveness training can all help to build her resources and her ability to keep herself safe.

Conclusion

For many women who experience both violent relationships and mental health problems, the issues intersect in complex ways that prevent generalizations. Safety planning therefore needs to be a highly individualized process. It should be anticipated that discussions about risk, threats, dangers and planning for safety will take longer with someone with these intersecting issues (and even more so for women with additional substance use concerns). Safety planning will need to explicitly address internal (emotional) as well as external threats to safety. This discussion should help her to plan more effectively for times of crisis and be more realistic about the strategies she has available to her. Identifying what she is in control of, as well as what she is not in control of, is vital to help support her confidence and self-efficacy.

Peer and informal supports can be as helpful (sometimes more so) as professional supports. Continually supporting a woman in building her personal/peer support networks is critical in creating a wide network that she can draw on for all times of her life. Seek out those local professional supports that are sensitive to women with intersecting violence and mental health concerns and that aim to help them on their own terms. Review safety plans regularly with women. Check whether she feels her plan is still helpful and relevant, particularly after a crisis has taken place. Aim to strengthen her overall her confidence that she can indeed take steps to help herself and her dependents. Help her to see that each small step she takes can help to move her towards safety and wellbeing, however painstaking the process may be.

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The International Community for Hearing Voices
www.intervoiceonline.org
This is the website for *The International Community for Hearing Voices* which is an excellent resource on the experience of hearing voices. It includes many different perspectives on the voice hearing experience and a good number of helpful resources, publications, research projects, training opportunities and events. Some of the readings here will be very helpful for working with women who are in different states of reality or having unusual experiences commonly associated with psychosis.

3.4 Safety Planning with Women Using Substances

By Tessa Parkes

3.4.1 Substance Use And Safety: Making More Connections

"Substance use and intimate partner violence are not linked in a linear manner, but interconnect in a web of social and structural issues" (Greaves et al 2006).

For many women experiencing violence, patterns of substance use are closely linked to the violence and abuse that they are experiencing. This link should not be understood as a causal relationship, *"but [as] one where the practice issues of safety planning, and identifying the strategies of power and control, need to be addressed in the context of, and intersection with, problematic substance use"* (The Stella Project 2005). In addition to this, and as described earlier in this tool kit, research has shown that as many as two-thirds of women with substance use problems may have a concurrent mental health problem such as depression, post-traumatic stress disorder, panic disorder or an eating disorder (Poole 2004). This means that many of the women you work with will be trying to cope and manage all three problems: violence, mental health problems and substance use. While the sections on safety planning for a woman with mental health problems and substance use problems have been written separately, there is obviously much overlap in the issues and in how they present for women in their lives. We hope you will start your safety planning process with a focus on violence, and then add on mental health and substance use issues when appropriate to do so.

> *"It is important for anti-violence services to work from the assumption that the women they serve will likely need to examine their current substance use in the safe context that an anti-violence service can provide. And the work that anti-violence services do with women on safety planning and identifying the workings of power and control needs to be informed by the realities of problem substance use"* (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4 2007).

To undertake effective safety planning with women who use substances, we need to understand the context of their lives and the interconnectedness of violence and substance use. There are many interconnections, for example:

- Many substance-using women who are in violent relationships were introduced to drugs by their partners, who then use substances to gain and maintain power and control.
- Many women with substance use problems began by using substances that were prescribed by their physicians.
- Alcohol and drug use, by the perpetrator or the women herself, is associated with greater severity of injuries and increased lethality rates.

- For IV drug users there may be risks associated with their partner using the drug use to abuse them, by, for example:
    - forcibly establishing drug use in the context of a relationship
    - forcing women to trade sex for drugs
    - determining the woman's drug supply
    - shooting up for the woman
    - deliberately using dirty needles or cottons or missing a vein on purpose (Bland 2001)
- A woman may be dependent on her abuser for access to drugs and this may be a factor preventing her from leaving.
- The compulsion to drink or use may make it difficult to access services such as shelters, advocacy or other forms of help.
- Service providers may see women as having reduced credibility if they have substance use problems, which can reduce their access to community supports.
- The wider impact of a chaotic lifestyle may also create problems, with a woman having little control over who is around her and her environment in general.
- Women in violent relationships who have substance use problems often believe that their use of a substance means the violence against them is warranted.
- Active and regular substance use can make it harder to escape from a violent situation or to heal from past abuse.
- For a woman experiencing violence, substance use treatment may be seen as less urgent than getting safe.
- Women who use substances may be more reluctant to seek assistance or contact police for fear of arrest, deportation or child protection service involvement.
- A woman may fear that she will not be believed if she makes a complaint—this may have been borne out for her in prior experiences.
- If she is in recovery from using substances, she may fear relapse if she leaves to face an unknown future (Alaska Network on Domestic Violence and Sexual Assault 2005).

We have included a Power and Control Wheel for Women's Substance use (O'Neil 1996, adapted from the Domestic Violence Intervention Project, Duluth) in Appendix 21. This provides more detail on how substance use can be dynamic in violent relationships.

3.4.2 Risks To Safety

Because of this interrelatedness of violence and substance use, cessation of drinking and drug use alone cannot ensure safety. Indeed, recovery is often accompanied by more danger for women, as the violent partner finds that they are less able to control them than previously. They may seek to gain new ways of control and to sabotage recovery or treatment efforts. The exact risks will obviously vary for different women; for example, in rural contexts further isolation and disconnection from social and community supports may be particularly destructive, in addition to the lack of anonymity.

When under the influence of substances, a woman may be less able to accurately assess the level of danger posed by a perpetrator, and she may have impaired judgment and thought processes in a number of areas that make safety planning more difficult:
- She may think she has more power than she does and can defend herself against her partner during a physical assault.
- She may find it more difficult to make decisions that might protect her from the abuser.
- She may have a harder time recognizing options or gauging her safety if a situation escalates.

- She may have no memory or a distorted memory of violence that happened when she was under the influence; she may think she is able to handle it.
- She may fail to remember how an injury was sustained or fail to remember making a police report.
- She may find it more difficult to remember a safety plan.

Despite many of these difficulties we need to still see the woman survivor as the expert on her own and the abuser's behaviour and likely responses. We can combine her expertise with our professional wisdom and research evidence.

3.4.3 Conversations Aimed At Reducing Risk And Increasing Safety

"Critical to supporting women with substance use problems is reducing shame about having a problem, promoting understanding of substance use and its risks, as well as eliciting hope that change is possible" (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 3 2007).

Given the shame, guilt and other negative emotions connected with substance use for women it is vital that our conversations with them acknowledge these negative emotions and show our respect for them as women and for their struggles:

One of the most important interventions you can make is to have a conversation with a woman where her substance use is discussed, she is asked about how her use affects her and what she needs to stay as safe as possible. Crucially, we also need to ask how her or her partner's substance use is affecting the violence she is experiencing. A woman may find it easier to talk about her partner's use before she feels safe enough to talk about her own.

Questions to ask a woman who is using substances to help with safety planning include:
- Does your partner use your drinking or drug use to hurt you? If so, how?
- Has your partner used alcohol or drugs to control/threaten/shame you? If so, how?
- When you were not drinking or using drugs in the past, what helped you to cope? Can you do that now?
- Can you tell me why it may not be safe to use when someone is being violent towards you/stalking you?
- How can your drinking or drug use (together with your experience of violence/trauma) affect your parenting/housing/police response/legal response/interactions with MCFD, other systems or issues?

Recognizing that violence towards women can be connected to an increase in use or be a relapse issue (can make women turn back to using substances after having worked on quitting) is crucial (www.accessingsafety.org).

3.4.4 Strategies To Use To Increase Safety: The Value Of Harm Reduction

A harm reduction approach can be very helpful when discussing women's safety when she uses drugs or alcohol. A conversation focused on altering use provides more room to work together and provide support than a conversation promoting abstinence. For example, she could consider switching to safer drugs, reducing the number of drugs used, eating before drinking, etc.

Another approach would be to ask her questions about the context of her use and how this context creates additional vulnerability. Questions such as
- Where do you commonly use/drink?
- Who is around when you are using?
- What dangers do these people present to you?

Exploring together how a woman may keep herself safer in potentially unsafe contexts and around unsafe others may also be very helpful for her. You can help her to explore what choices she may have in exerting control in potentially risky situations. Questions that may be helpful here include:
- Are you able to use/drink with safer people?
- Are you able to drink/use in less risky places?
- What can you do when others'/partner's threatening or risky behaviour starts to escalate?
- Is there someone you trust whom you can call to come and help you if things start to escalate?

Some other areas you may want to consider are:
- Providing information—Provide information (in different formats) to women who use substances on their increased risks and ask for their collaboration in discussing ways of minimizing the risks associated with their substance use (see section on harm reduction approach for more ideas here).
- Risks from treatment—Substance use treatment can be risky for women in a number of ways:
  - They may encounter re-traumatizing practices as part of their treatment, such as feeling coerced into particular ways of stopping or reducing their use.
  - They may encounter approaches that add to their shame and guilt rather than offering them acceptance and hope.
  - They may not be able to access women-only services in their local area, which may make them vulnerable to being in physically unsafe or emotionally unsafe environments.
  - They may have to make a choice between staying with their children and getting treatment. This may be risky in a number of ways, particularly if the woman fears for her children's safety or fears that she will lose custody if she places herself into treatment.
  - sWhere possible, try to help a woman to access treatment settings that are sensitive to the needs of women in violent relationships. This is not always possible, particularly in rural and isolated areas. If not possible, try to maintain contact with a woman while she is in treatment to continue your support.

Sometimes new risks are presented when women access substance use treatment. For example, women who access methadone programs may be tracked by abusers because of the need to appear daily at a set time for their prescription. This and other individual risks need to be considered when drawing up a safety plan.

- Attend to the substance use directly— If a woman has indicated that she wants to stop her substance use, then you could create a substance use recovery plan to work alongside the safety plan. This acknowledges that the two issues are profoundly related. If she does not want to make abstinence-

focused changes, then a substance use harm reduction plan can be discussed along with her safety plan (see Moving Towards Safety: Using a Harm Reduction Framework). Ideally, a referral to a woman-centred substance use/addiction service would occur when a woman is ready to quit or substantially alter her use. With her consent, it would be important to share her safety plan with her addiction worker, so that the recovery plan they create complements and supports her safety plan. Checking in with her on her recovery efforts and evaluating any impacts on her safety remains part of the anti-violence work.

- Referrals and support from other agencies—Where at all possible, try to partner with appropriate woman-centered substance use services to facilitate referrals and coordination.

Good Practice Example

"At the Jean Tweed Centre, a women's addictions treatment centre in Toronto, counsellors have identified the parallels between supporting women in developing violence/trauma safety plans and relapse or risk reduction plans regarding substance use. Helping women make the connections between their safety planning, growth and change in both areas can be facilitated by both violence and substance use counsellors" (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4, 2007).

- Peer and mutual support— Find out if there are any integrated support groups (for substance use and violence against women) in your area, and if not, think of helping women start one. It can also be helpful to have copies of "A woman's way through the 12 Steps" by Stephanie Covington available in your services to help women get what they want from traditional support groups. (Dr Covington's website is http://www.stephaniecovington.com/ and to order the book go to http://www.amazon.ca/exec/obidos/ASIN/0894869930.)

Alternative Support Groups

There are alternatives to the 12-step groups that provide options for those who do not feel comfortable with this approach. They are not as commonly available as 12-step groups but they tend to also have websites and online meetings as well as meetings in larger cities. The 16 Steps of Discovery and Empowerment group, developed by Charlotte Kasl, interprets the 12 steps in alternative ways that are more suited to women and other marginalized groups of people. The groups are based on approaches in her books *Yes You Can!* and *Many Roads: One Journey: Moving Beyond the 12 Steps*. Her version of the steps encourages those that attend to examine beliefs, addictions and dependent behaviour in the context of living in a hierarchical and patriarchal culture. See www.charlottekasl.com and use the email address at the website for information on online support groups.

Good Practice Example

Victoria Women's Sexual Assault Centre (VWSAC) identified the need to provide more in-depth support for women experiencing Post Traumatic Stress Disorder and substance use problems. They observed that women with trauma-related, mental health and substance use problems are often in crisis and rotate through services trying to get their needs met. VWSAC fostered a community collaboration that provides an integrated treatment model utilizing the *Seeking Safety* group model (Najavits 2002) as its foundation.

The programming consists of two connected yet stand-alone groups:
- *Seeking Information* (three or four weeks) explores the links between trauma and substance use. This group provides women with basic information and skills before making the commitment to a 12-week group;
- *Seeking Understanding* (11 or 12 weeks) examines specific topics related to trauma and substance use in more depth.

The groups are co-facilitated by a trauma counsellor and a drug and alcohol counsellor. Group goals include:
- Building awareness of the effects of trauma and substance use, the connection between the effects of trauma and substance use, and new ways of coping without substance use;
- Learning about new skills and having an opportunity to practice. Skills include things like problem solving, safety planning, asking for help, taking care of yourself, and harm reduction or abstinence;
- Increasing positive beliefs: decreasing shame and isolation and increasing self-esteem, self-acceptance, personal power, trust in self and others, self-awareness, hope (change is possible), compassion for self, and internal and external resources. (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4, 2007)

Their materials on working with women to assess potential risks, dangers, triggers and potential relapse situations, and to build internal safety, are excellent resources. Resources are given to women that help to develop self-caring and self-soothing skills and routines and containment strategies and to build the ability to tolerate painful feelings (see Appendices 14–20 for the resources we have been given kind permission to reproduce in this toolkit). Two additional resources from the VWSAC are What inspires my healing? (Appendix 22) and How substance use prevents healing from PTSD (Appendix 23). These are excellent resources to consider sharing with women.

Substance use may reduce a woman's ability to gauge her level of risk

3.4.5 Additions To Safety Plans

When we are helping a woman with her substance use we need to remember that she may not have the autonomy or safety to be able to reduce her use without negative repercussions from an abusive partner.

In the context of drug or alcohol use, a woman may need to make specific safety plans or have additional aspects to her plan. Violence against women, drug overdoses and withdrawal from substances can all be lethal, so it is vitally important that the risk from each is assessed as well as the risk of a woman harming herself deliberately. These assessments should be reviewed regularly because of possible frequent changes in a woman's situation and emotional wellbeing. The Alaska Network on Domestic Violence and Sexual Assault has a resource kit called *Getting Safe and Sober: Real Tools You Can Use* on their website www.accessingsafety. org. The following suggested additions to a woman's safety plan have been taken and adapted from their tool kit and other online resources. This is an abstinence oriented safety plan and will not be appropriate for all women.

Mini Safety/Sobriety Plan at a Glance
- **Strategize –** Steps to reduce risk/use
- **Develop –** Options to keep safe/sober
- **Identify –** Trusted allies/safe sponsors
- **Plan –** Means to escape abuser/drugs
- **Discuss –** Referral resources
- **Avoid –** Danger/persons/places/things
- **Tools –** HALT/one day at a time.

This last point encourages a woman to recognize vulnerability cues such as HALT (be aware when you are hungry, angry, lonely or tired) and take one day at a time in moving towards safety and recovery. Understanding and planning for the physical/emotional/cognitive/environmental triggers and other cues indicative of risk is very important (see Appendices 13-17).

The following script could be added into and amended for use in a woman's safety plan where appropriate:

If drug or alcohol use occurs alongside violence in my relationship with my partner, I can enhance my safety by some or all of the following:

I will try to remember that:
- It is easier to keep safe when I am not using substances[1]
- Alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services
- I find it hard to ask for help when I am using or drinking.

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1   This is generally the case, but some women may be safer when they are using with their abusive partner.

Things I can do:
- I can call _____ for support when I feel like drinking or using to cope.

- The following people/places/things can be unsafe for me
  _____

- My warning signs that I am getting stressed and craving substances are
  _____

- and this is what I will do in these situations to try to keep myself from drinking/using and to try to keep myself safe
  _____

- If I am going to use, I can do so in a safe place and with people who understand the risks of violence and are committed to my safety. I can
  _____

- I can also
  _____

- If my partner is using/drinking I can
  _____

- I might also
  _____

- To safeguard my children I might
  _____

- Other things I can do to help me feel stronger are

(Alaska Network on Domestic Violence and Sexual Assault 2005)

This script has also been placed in Appendix 24 as a handout.

3.4.6 Knowing When To Act Quickly: Managing Withdrawal And Overdoses

It is important to be aware of indicators of withdrawal or overdose in case you need to act quickly to get medical help. Drug emergencies are not always easy to identify. If you suspect a woman has overdosed, or if you suspect she is experiencing withdrawal, give first aid and seek medical assistance.

Effects of Different Drugs
- An overdose of narcotics can cause sleepiness and even unconsciousness.
- Uppers (stimulants) produce excitement, increased rate of heartbeat, and rapid breathing. Downers (depressants) do just the opposite.
- Mind-altering drugs (hallucinogens), including LSD and other street drugs, may produce paranoia, hallucinations, aggressive behaviour or extreme social withdrawal.
- Cannabis-containing drugs, such as marijuana, may produce euphoria, relaxation, impaired motor skills, and increased appetite.
- Legal prescription drugs are sometimes taken in overdose to achieve effects other than the therapeutic effects for which they were intended. This may lead to exaggeration of their effect (as can happen with uppers and downers), or serious side effects. (Adapted from www.helpguide.org.)

Drug overdose symptoms vary widely depending on the specific drug(s) used, but may include:
- Abnormal pupil size
    - Dilated pupils (enlarged)
    - Pinpoint pupils (very small)
    - Nonreactive pupils (pupils do not change size when exposed to light)
- Sweating
- Agitation
- Tremors
- Convulsions
- Staggering or unsteady gait (ataxia)
- Difficulty breathing
    - Shallow, decreased breathing (respiratory depression)
    - Labored breathing
    - Rapid breathing (tachypnea)
- Drowsiness
- Unconsciousness (coma)
- Hallucinations
- Delusional or paranoid behavior
- Violent or aggressive behavior
- Death

Drug withdrawal symptoms also vary widely depending on the specific drug(s) used, but may include:
- Abdominal cramping
- Agitation
- Cold sweat
- Convulsions
- Delusions
- Depression
- Diarrhea
- Hallucinations
- Nausea and vomiting
- Restlessness
- Shaking
- Death

Withdrawal from Benzodiazepines

Withdrawal symptoms can include insomnia, panic attacks, agitation, hallucinations, paranoia, depersonalization, derealization, depression, pressure in head, rebound anxiety, loss of appetite, weight loss, visual distortions, flashbacks, lack of concentration, agoraphobia, dizziness, sweating, nausea, nightmares, palpitations, creeping sensation in the skin, increased sensitivity to light, touch and smell, pins and needles, numbness and seizures and sometimes death (taken from www.benzo.org.uk).

Depressant Overdose Symptoms

- Moderate: uncontrollable nodding, inability to focus eyes, excessive drooling, pale skin colour, incoherent speech
- Serious: awake but unable to talk, body very limp, erratic or very shallow or slow breathing, excessive vomiting
- Severe: unconscious, blue skin, not breathing, can't find a pulse or pulse shallow and erratic, choking or gurgling sounds, lying in their vomit.

Stimulant Overdose Symptoms
- Moderate: incoherent speech, extreme paranoia, pale skin colour, jaw or teeth clenching, aggressiveness, minor shakes, excessive sweating, clammy skin, very rapid pulse
- Serious: inability to focus eyes, vomiting, foaming at the mouth, pressure or tightness of the chect, unable to talk, erratic pulse and violent actions
- Severe: seizures, unconsciousness, choking or gurgling sounds, not breathing, no pulse From www. heretohelp.bc.ca/publications/factsheets/crises_emergencies.shtml)

Alcohol Withdrawal Symptoms
Withdrawal symptoms often develop in three stages:
1. The initial phase, which begins within a few hours after drinking stops, includes tremulousness ("the shakes"), irritability, nausea and vomiting, and difficulty sleeping. These symptoms reach peak intensity within 24 to 48 hours, and subside in two or three days. Alcoholic hallucinosis— very real "bad dreams" or actually seeing or hearing things that are not there— can occur during this phase.
2. In the second phase, convulsions (seizures, "rum fits") can develop within 24 to 48 hours after stopping even heavier drinking. Convulsions have been reported to occur as long as five and up to 20 days later. Except in persons with epilepsy, the standard treatment of moderate to severe withdrawal described below is usually adequate.
3. Delirium tremens (DTs) is the third and most serious stage of alcohol withdrawal. They occur four or five days after prolonged, heavy drinking stops, at which time the person becomes severely agitated, extremely confused and disoriented, and has dilated pupils, fever, and a very rapid heart rate. Frightening hallucinations and bizarre delusions can also occur.

Reassurance and supportive nursing care in subdued surroundings are the basis for treating alcohol withdrawal states. Chlordiazepoxide (Librium), diazepam (Valium), and other benzodiazepines are the drugs most commonly used. Particularly with DTs, electrolyte imbalances should be corrected and adequate fluids administered; hallucinations should be treated cautiously. Thiamine (vitamin B1) is usually given orally or intramuscularly to most patients treated for significant alcohol withdrawal (taken from information at www.aadac.org).
Try to make sure that women are well informed about these indicators— share this information with them if appropriate.

Conclusion

> **"Safety includes knowing you are not being labelled or judged" (Alaska Network on Domestic Violence and Sexual Assault 2005).**

As with the support of women with intersecting violence and mental health concerns, the issues for women with intersecting violence and substance use concerns are complex. Safety planning will need to take this into account and generate individualized plans that attend to the specifics of a woman's particular situation and that respond to changes in these situations. Allow plenty of time and patience for this process. Draw on harm reduction ideas to support your work with women, because this allows for much more creativity than simply taking an abstinence approach. Because these processes require honesty and trust to be effective, women require positive and non-judgmental supporters to help them with this challenging work. Ensure you can provide a woman with this in your working relationship and be prepared to meet her wherever she is at.

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4.1 Survivor's and Service Provider's Stories

A Survivor's Story

I had never talked about my past with a professional, but when my condition started to deteriorate, I came to see this counsellor. I was apprehensive in the beginning, but was determined to change my situation. I met this counsellor within three days of my call to her office.

My biggest challenge was my inability to recognize my own strengths, which my counsellor helped me to discover. Other than, that the scariest part was when I was asked for the first time to accept and acknowledge that I was having a flashback. I thought I might have a panic attack, but the counsellor's presence and my "safe place" and the safety of my own home helped me immensely. I would say that the most helpful component of my treatment was the gently directive approach of my counsellor. Her kindness and soft-spokenness were also very helpful; I felt from the first session that I could trust her completely.

Controlling my breath whenever I had chest pains and knotted stomach was very relieving; the relaxation techniques and the visualization are still my daily routine. Another relief is that I will not have to see my ex-husband face-to-face and everything will be sorted out by the lawyer. But who cares; even if I did have to see him, I am not scared anymore. That was then and this is now.

I still see my doctor on regular basis but do not take any medication for my anxiety. I do take medication for my age-related physical complications. I have lots of friends now and keep myself really busy socially as well as around the house.

It's been eight months since I stopped seeing my counsellor but I still do all the things she taught me and I feel great.

I would say that the most helpful component of my treatment was the gently directive approach of my counsellor.

A Service Provider's Story

My client is a 65-year-old woman who was seeking support to deal with her historical issues of physical and emotional abuse. She stated that she had been diagnosed with an anxiety disorder and panic attacks. She had been on anti-depressants and benzodiazepines (Clonazepam and Alprozelam) for the past 15 years. The client was resistant to involvement of the mental health unit and that was respected. However, she was encouraged to visit her family doctor on a regular basis.

She stated that she was divorced 25 years ago and had had no contact with the offender since then, but in the near future, she might have to face him in the court to get her share of his pension. This triggered her anxiety disorder, and her symptoms became more prominent and intrusive and affected her daily coping. Her prominent somatic symptoms were: pounding heart, hot flushes, shortness of breath, tingling sensations and "knotted stomach."

She was offered one-on-one sessions. The counselling relationship started with creating a safe environment for her so that she could re-frame her story without any fears. For a stronger sense of safety, the client was offered these sessions in her own home, in addition to developing resources such as containment, going to a safe place and breathing through discomfort. The triggers were identified and the relationship between her mental health and her past experiences of abuse was explored. The challenges in the process were that she had never been educated about her mental health, nor provided with any supportive counselling previously, and lacked effective coping skills for her symptoms.

Along with counselling, self-care techniques were provided to the client in the form of relaxation and meditation, yogic breathing, biofeedback and visualization. A lot of education was provided on all issues of concern, and material was collected from mental health units also. The client's goals were met within a time frame of months. She began to recognize her own strengths and even now (after eight months of closure) she follows her self-care routine. I would like to express my gratitude and admiration for this client for being so motivated and committed to the counselling process.

4.2 Working Effectively with Immigrant and Refugee Women on Safety

By Kashmir Besla

4.2.1 Immigrant And Refugee Women And Mental Health

Immigrant and refugee women face many challenges as they integrate into mainstream culture. Women of colour emigrating from non-English-speaking countries can experience many difficulties. Immigrant and refugee women often have many struggles with employment, language barriers and housing. They may be experiencing financial difficulties and lack a support network. When women find themselves struggling with mental health issues, this can be a frightening and unsettling time for them. Their only support may be a family physician, and the experience can be isolating. Like all women in this situation, immigrant and refugee women often do not know what is going on for them, and it can take a long time for an accurate diagnosis.

> Immigrant and refugee women may not be appropriately diagnosed due to a lack of culturally and linguistically appropriate and accessible diagnostic tools. For example, learning and developmental disabilities often go unacknowledged by professionals, as there may not be an assessment tool in her language or at her level of literacy.

Immigrant and refugee women often feel that something is not quite right with how they are feeling and are not able to express their experiences. They may even attempt to hide their fears because they do not want anyone to think that there is anything wrong with them. Women will often try to talk themselves out of feeling in ways they believe they should not feel. The practical tasks of adjustment to a new country are difficult enough, and it is often too much to acknowledge internal difficulties.

As with most people, immigrant and refugee women often have little understanding of mental health issues. Some may attribute their experiences of violence and mental health issues to karma or fate, and this view could be encouraged by those around them. Attributing these experiences to karma or fate, immigrant and refugee women assume blame for their experiences and become more isolated in dealing with them. Many people believe that little can be done to help someone with a mental health problem. Issues of mental health are generally not discussed in most cultures, creating many myths and misconceptions of what mental health and mental health issues really are. Historically, in some cultures mental illness was believed to be associated with demons that had possessed the mind and body of its victims. Such beliefs perpetuate further misconceptions and isolation. Even present-day language used to describe mental health problems can be disrespectful and unkind.

The stigma of having mental health issues can be overwhelming for many immigrant and refugee women. As with many other areas of their lives, they are taught to "save face," and having mental health issues may appear to bring unwanted attention to them. Their families and partners may not understand what is

happening, and their own misconceptions of mental health issues may affect how they relate to the woman. One woman that I worked with said that her family felt that she was damaged because her brain was not working the way it was supposed to. This attitude towards mental health problems caused the woman to want to hide her struggles even more. Between trying to settle into the western culture and taking care of the family, and the added challenge of mental health problems, women often have a difficult time trying to balance and understand everything.

Many women are looking for fast solutions for their problems. On numerous occasions I have heard women insist on a quick remedy for their mental health issues. Many believe that the professional should be able to make them feel better right away. Other women put too much emphasis on medication and believe that the "magic pill" should improve their lives. Some immigrant and refugee women believe that Western medicine should be able to cure them quickly of their ailments. When women are struggling with treatment options, it can be reassuring when their worker validates the positive coping skills that they are already using, such as prayer, exercise or another modality that is culturally normative. Women often feel isolated when they are going through an experience that they believe others cannot relate to. It is helpful to remind women that there are many other women that are having similar experiences and are able to manage their lives. Women also need to be educated as to how their management of their mental health issues will affect their children. Women can be guided as to the kinds of conversations they can have with their children regarding parental mental health issues. These conversations can help put children at ease and have a better understanding of their mothers' experience.

Immigrant and refugee women are often dependent on family physicians as a form of support. They sometimes require family members to help them with language skills to be able to have a conversation with the doctor. In the name of convenience, family members are often asked to interpret, but in order to have accurate interpretation, professional interpreters should be used. This allows for accurate information going from the woman to the doctor and back to the woman. When professional interpreters are not available, it is helpful to brainstorm with the woman who in her extended circle of supports (friends, neighbour, someone from temple, etc) could be a safe and trusted interpreter. The issue of interpretation becomes critical when violence and other forms of power and control are present in the home, as a woman's safety could be highly compromised if a family member provides interpretation or the person interpreting does not maintain confidentiality. Family members may misinterpret information, may not relay information correctly or may prevent a woman from speaking honestly about her experiences.

Immigrant and refugee women who have experienced trauma as a result of war, natural disasters, physical or sexual assault, prison and other life experiences and are experiencing symptoms of complex post traumatic stress will feel especially challenged. They may feel that their nightmares and flashbacks should dissipate now that they are in a safe country. They will need to learn that their symptoms can last for a long time and there are techniques to try to cope. They may require advocacy and education services with their family members and/or other service providers to delineate their experiences as symptomatic of the torture or extreme trauma they have endured rather than interpreting their symptoms as a mental illness.

4.2.2 Mental Health Case Study

When I think about immigrant and refugee women and mental health, one woman that I worked with many years ago comes to mind. She had immigrated to Canada shortly after marrying her husband, who had sponsored her from a country in Asia. She moved into a home with his parents, his brother and his sister. The first few months of the marriage were all right, but soon after, the woman said that she was being belittled and put down by her mother-in-law. The husband felt that his wife was being disrespectful to his mother, so tension between the couple began to build over the years. The woman gave birth to a daughter and was told

by her mother-in-law that she was no good because she had a female child. She would often call her crazy and stupid. The husband felt caught between his mother and his wife, but chose to believe his mother's version of events over his wife's. The anger between the couple escalated and the husband hit his wife. This happened sporadically for a few years until the woman felt she had to leave her home in order to protect herself and her young child. She also felt that she was being pushed out of the home by the family's verbal intimidation and abuse. The mother and child moved into a place of their own, barely surviving on the little income that the woman had.

I met the woman when the child was seven years old and began to display unusual and disturbing behaviours at school. She was insisting that she had magic powers, she was talking to trees, and she was isolated from her peers because of her unusual behaviours and lack of social skills. In working with the mother, it became clear almost immediately that she was experiencing difficulty in her life, and that the mother's experiences were influencing the daughter's view of the world. After many sessions of working together and building trust, she told me about her ability to see things that I could not see, she talked about her magical powers, and provided great detail about "bad men" that broke into her home and tried to hurt her and her child. I worked with this woman for many months to try to help her discover what was real and what was not real. She was certain that her reality was much more believable than mine.

As a result of other disclosures that the daughter made, she was removed from her mother's care and was living with her father. He had remarried and appeared to have a good relationship with his wife. The mother was very angry and sad at the time, but over time, she accepted that she had not been able to care or provide for her child in the way that she felt she should. The mother unfortunately was unable to admit or acknowledge her mental health issues and refused to receive further assistance from professionals. She does continue to have supervised visits with her daughter, and has tried to maintain a relationship with the daughter she loves dearly.

In my work with her, she made it clear that she did not want to be viewed as a "crazy lady" because she was well known at her place of worship and she did not want people to see her in a negative light. She did not want to see a psychiatrist or any type of medical doctor. She felt she had the means to take care of herself and she did not require any medication for her visions. I worked with this woman for many months and recognized that she had many skills and talents, and that she would not be defined by a mental health issue. She was able to function in most parts of her life. She had a few friends and she practiced self-care. Although she had a serious mental health issue, she had managed to create a life that she was comfortable with, and she would access further services when she was ready to.

4.2.3 Ways For Workers To Engage With Immigrant And Refugee Women Who Experience Mental Health Issues

Meet The Client Where She Is At

Receiving assistance from service providers can require a great deal of effort on the part of immigrant and refugee women. Refugee women in particular may have had unsafe experiences with people in authority and may be very wary of connecting with people in power. This may be particularly evident with law enforcement personnel and court workers. Being aware of this and other barriers and recognizing her effort and fear can put women at ease, and remind them of their ability to help themselves. Don't rush into issues without taking the time to build trust and strengthen the relationship. Immigrant and refugee women are sometimes faced with language barriers, and may not know where they can receive service or what is expected of them once they do receive service. A woman may not have support from her family (or may not have family available in the country), as they do not want her to share her struggles with anyone for fear of how the family will be perceived.

Be Aware Of What You Bring Into The Room

It goes without saying that the service provider and client relationship is an imbalance of power. The service provider is in a position of power and the client may be feeling vulnerable. Naming this to the client can be helpful as it tells the client that you have also recognized the imbalance. Being aware of what the service provider brings into the room as far as ethnicity, the way she is dressed, her tone of voice and body language can influence how the client perceives she will relate to the worker.

Facilitate Open And Respectful Discussion

When working with immigrant and refugee women, many questions about the clients' worldview will arise. Asking questions about their experience is important, but remember to ask yourself, "For whose benefit am I asking this question?" I recall working with a young South Asian woman, and her telling me that she was also seeing a psychologist once a month. She said that she did not find it useful to talk to him because their sessions were spent with her explaining different aspects of her culture to him. Instead of talking about the serious childhood abuse she experienced, or her medications, or her depression, he wanted to know more about her culture. He did not give her an explanation for this request, nor did she find it useful in addressing her depression.

Challenge Misconceptions And Stereotypes

Like most cultures, immigrant and refugee women have misconceptions and stereotypes about what mental health issues are about. They may be carrying these ideas from what they have heard and what they have learned. It is important for a woman to know that having a mental health issue is only one part of her life and not the whole of who she is. Stigma about mental health issues is a form of disrespect, and that disrespect needs to be challenged and addressed.

What Other Challenges Of The Migration And Settlement Process Is She Struggling With?

Immigrating to and settling into a new country can be a challenging process. Ask the woman what other challenges of the migration and settlement process is she struggling with. Talk about what she is experiencing, and how these experiences are affecting her mental health. Is she seeking employment, attending school or looking for housing?

Find Out What Is Happening At Home

Family life can have a positive or negative affect on women's health. Ask the woman what is happening at home. Is she raising children, is she married, or a single parent? Is she taking care of others in the home? Does she stay home alone, or does she have people around her throughout the day? Are there issues of violence or abuse in the home? If there are, a safety plan should be put in place. A safety plan that is used with non-immigrant women is useful for all women. There are other issues to consider as well. The resources in mainstream culture may not be ones that the woman is familiar with, or would consider. For example, would she call 911, does she understand what a transition house is, does she know about victim services and counselling supports? Does she believe that information is kept confidential and will not be released to her partner or community, and does she know what the limits to confidentiality are? Each woman may need a specialized safety plan, one which she is most likely to access in a time of crisis. If the ideas created in the safety plan are those of the worker's and not the client's, she is less likely to follow through. It is important to think outside the box and involve the woman in her own safety plan.

Empower Women To Care For Themselves

Empowering women to care for themselves is the best tool that workers can provide. If a woman recognizes the value of learning to put herself first, she will be better able to cope with all of the other challenges that life presents. Most women are not encouraged to do this, and immigrant and refugee women are often even less so. Encourage her to use spirituality, meditation and prayer if these are her preferred ways of taking care of herself. Learning the value of self-care will be a gift for life, and one that will help manage her mental health issues.

Aim For A Holistic Approach

Not all methods of counselling or support work for all people. It is important to try a variety of approaches when working with immigrant and refugee women. Simple, effective tools of self-care and management are the most effective. The concept of speaking with strangers to manage one's life is still a newer phenomenon for most cultures. Let the woman know that she has choices, and that she can choose to take care of herself in ways that work for her. Many people either have friends and family for support, or they simply do not speak about certain subjects. Helping the woman to find the approach that works best for her will be the most helpful thing the worker can do.

Identify Supportive Friends And Family

Helping immigrant and refugee women to identify a list of people they can count on to help them through their journey is good way of ensuring that the woman will have others to turn to when you are not available. Most professional relationships are time limited, so it is important to put people in place for her to access. Sometimes women forget that they have a trusted friend that would want to help them out.

Talk About What It Means For The Woman To Have Mental Health Concerns

Shame can be a powerful influence in the lives of immigrant and refugee women. Helping to take that shame away from mental health issues is an important conversation to have with women. This experience does not have to be shameful, it can be empowering.

Refer To Culturally Appropriate Service Providers

Services for immigrant and refugee women experiencing mental health issues are limited, but it is important to familiarize yourself with any in your area. Sometimes a woman feels more comfortable speaking to a counsellor in her first language, as opposed to trying to express herself through broken English. It may also be a better fit because the counsellor will have a better idea about the culture, and may be more effective in assisting the women. On the other hand, some women do not want to see a counsellor from their own ethnicity for fear that information will not be kept confidential. Either way, the choice should be up to the woman, if options are available. Try not to make any assumptions about what would be most helpful.

Ask For Feedback

It is always good practice to ask for feedback from clients as to how they are experiencing your work together. Is she finding the sessions useful, is she getting what she needs, or is a different approach required? Many immigrant and refugee women will view the service provider as the expert and believe that whatever suggestions or ideas are presented will be most useful. They may even tell the service provider that they will go along with the advice that they are offered because they believe that they are unable to make good decisions in their current circumstances. Women have often said to workers, "Just tell me what I should do in this situation."

Some women will benefit from step by step written information, which they can take home and practice throughout the week. This would be helpful when women are working on self-care, or trying to create new routines. Talking about feelings, can feel too abstract for some women, so having information to take home will be more useful. Again, this is about having a respectful dialogue with the client to ensure that she is getting what she needs from the service.

It is always important to ask the woman what she hopes to achieve in working with you, and how she believes that this can happen. This would model the importance of her decisions as well as build trust. Does this woman want help with her mental health issues, or is she feeling pressured by outside sources to go and get help? Walking alongside the woman in her journey is the best support that any service provider can give.

Working with women who have mental health issues can be challenging and rewarding at the same time. It is important for the worker to assess their own comfort and abilities when working with women. A supportive team of colleagues and clinical supervision can allow the worker to feel comfortable with the ways in which she is assisting the client. Issues of mental health often are not presented in isolation. They can be connected to childhood abuse and trauma, violence and substance use. The woman may have been hurt by multiple perpetrators. Each woman will present her experience and story in different ways, as each situation is unique. Even within similar cultures, the experience of mental health issues and receiving supports will be different.

4.2.4 Barriers To Addressing Substance Use

Women in many cultures have been forbidden to consume alcohol and illicit drugs. The use of substance may have been considered a man's domain, and not something that a proper woman would engage in. As immigrant women are exposed to a culture in which they have choices about their lives, they are experimenting with many new lifestyles. As a result, many women have used drugs and alcohol recreationally, which can lead to using substances to numb emotional as well as physical pain. Combined with issues of mental health, this can be a frightening place for women to be. They often judge themselves in a very negative light, and are very ashamed for the choices they have made. It is often difficult for immigrant and refugee women to tell service providers about their struggles, as they feel they may be shunned further, because this type of behaviour is not expected of them. The stigma of mental health issues and misuse of drugs and alcohol, combined with violence and trauma, can create a challenging life for immigrant women. Service providers who are able to create an open space based on respect will be able to explore healthy choices in coping, which will allow the woman to share her most difficult problems and work towards healing.

Conclusion

As with all service provider and client relationships, creating safety, trust and a non-judgemental environment for immigrant and refugee woman will be the most effective way of allowing them to speak openly about their experiences with mental health and substance use issues. Women need to know that they will be heard and respected, and that the counsellor is there to support them through the counselling process. Some women will feel safer with workers from their own ethnicity, and others will feel comfortable with any worker that is empathetic and genuine. Being aware of the clients' needs and working with them in a respectful manner is the key to building trust and working together. As in mainstream culture, mental health and substance use issues still require a great deal of education and awareness, but each interaction with clients brings us one step closer to providing that much-needed support.

4.2.5 References, Resources And Further Reading

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4.3 Safety and Support for Women in Rural/Remote Communities

BY SARAH LEAVITT

Women in rural and remote communities who are facing violence and are using alcohol or drugs face many barriers when trying to access help. In this section we look at some of these barriers and offer suggestions for overcoming them.

4.3.1 Barriers To Safety For Women In Rural/Remote Communities

The BC Rural Women's Project produced a report in 2003 about some of the challenges facing rural women. These include a lack of:
- Affordable housing
- Public transportation
- Support services
- Health services
- Educational opportunities
- Telephone and Internet access
- Government services

These are all services that are important for women who are seeking help for substance use, mental health and violence.

The following summary of some of the specific issues facing women in rural and remote communities who are experiencing violence could also apply to women with substance use or mental health issues.

Creativity, resourcefulness and participation from other community partners are often necessary to assist a woman in a rural community to increase her safety.

Confidentiality for Rural Women Who Have Experienced Violence
Prepared by Nancy Taylor, Stopping the Violence Counsellor, Robson Valley Home
Support Society, McBride, BC

Maintaining confidentiality is vital when planning for safety with women living in rural, remote and farm communities.

Problems with maintaining confidentiality in rural communities:
- Many people have scanners capable of monitoring police radios.
- Even non-identifying information can reveal the identity of a woman and/or her children, i.e. when a woman from Highway 16 East with five children is the only woman in that area with five children!
- Roles that service providers fill may intersect with the roles women experiencing abuse fill, i.e. the children of a shelter worker may attend school with the children of a woman who is fleeing abuse.
- Extended family networks in rural communities share information between each other and tend to take sides.
- Women lack anonymity when accessing services in small communities. There is a fear that health care professionals and police will not maintain confidentiality.
- Gossip is a normalized form of communication in rural communities. There can be a perceived lack of confidentiality within service agencies when a women's story is discussed in the community.
- There is a general lack of anonymity in small communities. Women can be identified by the vehicles they drive, the routes they take, the people they associate with, etc. This can both threaten and enhance their safety.
- Safe Homes are located in private homes where it can be difficult to predict when other community members may drop by or call.
- Children staying in shelters are identified when riding on school buses.
- Safe Shelter Coordinators and Anti-Violence Workers become known in the community so assumptions about women accessing their services are easily made.
- Local 24-hour crisis line service is impossible in a small community because of lack of anonymity.
- **Historical relations with families and workers can limit access to services.**

Some dynamics of abuse in rural, remote and farm communities:
- Rural communities can be very different from each other so, although certain themes are common
- The problem has not been named; normalizing, minimizing and victim blaming are common.
- Intimidation tactics often include threats to harm pets or farm animals; farm women have witnessed the killing of animals so threats of femicide are very real.
- Firearms are readily available in farm and rural communities.
- Vehicles, farm machinery, power tools, etc. can be used to induce fear and terror.
- Farm women are often blamed for everything that goes wrong on the farm; crop failure, bad weather, animals getting sick, market and financial problems, etc.
- Difficulties in farming can be used as a justification for other abuses.

4.3.2 Ideas For Rural Safety Planning

Creativity, resourcefulness and participation from other community partners are often necessary to assist a woman in a rural community to increase her safety. These are some of the strategies that have been used by anti-violence workers to help women in rural communities:

- Set up "safe havens" in local businesses for women fleeing abuse. Recent projects in BC communities have resulted in a number of businesses volunteering to be places where victims of abuse can come for safety. Staff at the businesses are given information about which agencies to call or refer to, depending on the victim's wishes and the situation.
- Place an anti-violence worker in a doctor's office or the mobile library van to provide a less obvious place for women to seek help.
- Advocate for call boxes (direct lines to the police) on rural roads.
- Provide transportation to women to the safe house if there is no other transportation available.
- Create networks of family, friends and neighbours who are ready to help women in abusive relationships, or women struggling with substance use or mental health issues.
- Go to home visits in pairs to increase your own safety.
- Remind women to cover their tracks—offenders can often read foot prints and tire tracks in rural areas where there are dirt roads.
- Enlist the help of road maintenance crews to alert outreach workers or victim assistance workers when an offender's car is seen in a particular area. The woman is then alerted by anti-violence workers and given more time to get to safety.

4.3.3 References, Resources And Further Reading

BC Rural Women's Project: *www.ruralwomenproject.bcwomen.bc.ca*

Education Wife Assault: Rural and Farm Women: a fact sheet available: *www.womanabuseprevention.com/html/rural_and_farm_women.html*

Rural Women's Justice Guide: *www.owjn.org/info/rural1.htm*

Women's Rural Advocacy Programs: Problems of Rural Battered Women: a fact sheet available at *www.letswrap.com/dvinfo/rural.htm*

4.4 Working on Safety With Aboriginal Women on Reserve

Consultation for this section provided
BY MAGGIE MATILPI

4.4.1 Barriers To Safety

Many rural and remote communities are Aboriginal reserves or are located near reserves. Aboriginal women in these communities face additional particular barriers in terms of accessing services and maintaining safety.

In the summer of 2007, the provincial government held a series of "conversations on health" with Aboriginal people. When participants were asked about the important health issues for Aboriginal communities, there was a significant focus on substance use and mental health issues. Concerns included:
- Lack of access to health care specialists
- Lack of culturally appropriate services
- Short term funding only for programs such as tobacco cessation without any follow-up support
- Lack of trained medical and counselling staff to provide appropriate diagnoses, prescriptions, emotional support and long term follow-up and support
- Lack of follow-up in the community for people who have gone away to detox/treatment and returned
- Misdiagnosis of the effects of residential school—e.g. schizophrenia instead of post traumatic stress disorder
- Lack of services for children and youth who are using substances
- High rates of suicide and attempted suicide and lack of community supports and communication among services and bands—lack of discharge planning after hospitalization for a suicide attempt
- Overprescribing of psychotropic medications to elders; abuse of prescribed medications.

Anti-violence workers consulted for this section identified further barriers:

Lack Of Anonymity Or Confidentiality
- Her abuser's family may have a lot of power in band governance or in services such as mental health and may deny her services.
- She may have already experienced a lot of negative judgment from others in her community, which may prevent her from reaching out for service.

The Impact Of Intergenerational Trauma
The history of colonization in Canada, particularly residential schools, has had a severe impact on Aboriginal people. Most Aboriginal communities suffer from high rates of violence and substance use. People are often suffering from high levels of trauma and there may be a strong culture of addiction. Within this context, it can be extremely difficult for women to escape violence or recover from addiction.
- Violence may be generally accepted; women may be blamed for the violence they experience.
- Women may feel hopeless and trapped when they consider making changes.
- There may be little encouragement for people to stop using drugs or alcohol.
- The effects of drug or alcohol use, or the impact of FASD, may make it difficult for women to plan or make changes.

> ▌▌Intergenerational trauma or multi-generational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next. What we learn to see as "normal", when we are children, we pass on to our own children.... The unhealthy ways of behaving that people use to protect themselves can be passed on to children without them even knowing they are doing so. This is the legacy of physical and sexual abuse in residential schools." (Aboriginal Healing Foundation 1999)

The long history of Aboriginal children being removed from their homes has had a huge impact on communities. This legacy prevents some Aboriginal women from reporting violence or seeking help for substance use for fear of losing their children.

Colonization and racism have also led to a high level of poverty among Aboriginal people, which creates another strong barrier to escaping violence and addiction.

Consequences Of The Indian Act

The Indian Act became law in 1876. There have been many significant changes to the Act since that time, particularly changes in the mid-1980s to the definition of status. For example, before these changes, an Aboriginal woman would lose her status under the Indian Act if she married a non-Aboriginal man. Bill C-31 restored status to these women as well as others who had lost their status.

The Act governs many aspects of how the federal Canadian government deals with Aboriginal people. It affects taxation, housing, land rights, etc. Many parts of the Act only apply to Aboriginal people living on reserve. There are many implications of the Act, which cannot all be addressed here. The Act has been widely criticized by Aboriginal people.

Individual Aboriginal communities have some ability to determine how they will deal with certain rights under the Indian Act. For example, under the Act, members of a band have the right to housing on their reserve. If a woman from outside of a particular band marries a band member, she no longer has rights to housing in that community if she leaves him. However, the band may decide that she can stay on the reserve if she has custody of the children and the children are band members. Different bands will also have different policies about how to determine membership in the band. It is important to be familiar with the basic elements of the Act and especially how the community you work with has chosen to address issues such as the right to housing. (See Resources section for sources of more information)

Services Provided By The Band Versus Other Anti-Violence Services

Aboriginal women dealing with violence may use services provided by their band instead of services such as STV Counselling or Outreach programs or CBVAP. The band services are usually not women-centred but may be more culturally based, incorporating healing practices such as sweats and smudging. Many women benefit from traditional healing practices, but they may suffer from a lack of attention to safety particularly when services are not gender specific. On the other hand, they may not feel welcomed or accepted at non-Aboriginal services. And if they are, the services may be difficult to get to (only available on occasional basis, confidentiality is compromised as the entire community knows what day the service provider comes on reserve or requires travel to access), or not culturally sensitive.

Lack Of Resources For Youth

Many reserves have a high proportion of young people. However, there are few recreational resources and a high level of unemployment, leaving many youth with extra time and a lack of activities to fill it with. This context, combined with the emotional impact of trauma, inter-generational abuse and colonization, can lead to an atmosphere of partying and substance use, in which women are vulnerable to sexual assault and unplanned pregnancy. Activists suggest that increased options for support and recreation for youth could help address this situation.

4.4.2 Suggestions for Providing Support and Safety Planning

Acknowledging The Impact Of Colonization

An important part of supporting women who have experienced violence is putting their experience in context (see Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective for more information).

- Educate yourself about the impact of colonization and the Indian Act, the current state of Aboriginal peoples in Canada, and the history of the particular community you are working with (see end of this section for Resources that will help you).
- Check out how much information the woman has about these issues; explore (following her lead) the history of her own family and community. Help her make links between her own experience and the larger context.
- Be aware of and share with her some positive achievements by Aboriginal people—for example, the activism by Aboriginal women that led to the passing of Bill C-31 (which restored Aboriginal women's rights). Celebrate the strength and survival of Aboriginal people.

Addressing Mistrust Of Systems

- Many Aboriginal women may fear working with systems because of previous negative experiences of racism, including stereotyping, blaming, child apprehension, misdiagnosis, etc. Validate the reasons for women's fears and explore ways to address them.
- Women may be reluctant to sign documents such as Consent to Release Information forms because of the history of systemic abuses including forced removal of children. Suggestions for dealing with this include:
  - Document verbal consent and leave written consent for when more trust has been established, if possible.
  - Go over documents in detail to be sure she understands them (low literacy levels may also be an issue).
  - Ask if she has a trusted friend or family member who could review documents and witness her signature.
  - On release of information forms, provide a place where she can sign to revoke consent and make it clear that she has the right to do this.
- Some women have difficulty accessing services because their abuser's family has a great deal of power in the band council or in services such as mental health. Women may be denied service or may simply choose not to access services at all because of their fear of what the consequences might be. One strategy that might help is to see if there are workers within the services who are open to working with the woman and who would be willing to come to her home (or a central, less identifiable location such as a health centre) so that she does not have to go to the band office or an office identifiable as an anti-violence service.
- Many Aboriginal women want help for their abusive partners and will not phone helpers or police because they believe the justice system discriminates against Aboriginal men. As an anti-violence worker it is important to acknowledge the historic and current systemic biases that Aboriginal peoples face particularly within the criminal justice system while reminding a woman about her rights and working towards safety.

Getting Support From Band Council

- A woman may be reluctant to leave an abusive relationship because she could lose custody of her children. Seek assistance from her band to get letters of support and set up a safety plan for her children. In the instance of child welfare on reserves, a letter from a band is valuable.

Planning For Safety With Substance Use

- Ask her what her preference is to stay safe when she's under the influence of alcohol or drugs: start her safety plan with phone numbers of her preferred support network, band name and number, etc.
- Identify safe places for her to go when under the influence.
- Identify safe places for her children to stay when she is intoxicated.
- Plan for safety if her suicidal feelings tend to increase with substance use or withdrawal.
- Discuss how you will respond and follow up if she contacts you when under the influence. This is an important thing to discuss; the goal is to reduce the shame that women often feel after contacting a support worker while drunk or high. Remind her that you are there to support her.
- Familiarize yourself with detox and supportive recovery policies. There are services available off reserve for women who wish to leave the community for these services. Mental Health and Addictions Services provide workers who do assessments and referrals for beds. Services are limited in remote communities and the availability of travel subsidies depends on the individual community budget. Health Canada does not provide transportation to non-medical appointments. If your client is referred to a specialist, this will provide travel funds, so use it as an opportunity for her to get ex parte orders or attend other helper appointments: therapists, lawyers, interview for housing, establishing a separate bank account, seeking addictions counselling, leaving the relationship, etc.
- Bands will provide travel for their members to attend treatment, but band funding for Aboriginal women is always for an Aboriginal specific program. This is not always appropriate for the woman. Many women would be better served by a gender specific program such as Aurora in Vancouver, but will need advocacy to try to get travel subsidies to attend.

Planning For Safety In Cases Of Violence

- If there is no formal safe house or transition home in the community, seek a safe house for the time of crisis. Even when there is a transition home, some women will not feel safe to go there because the location is widely known or because they know some of the workers and worry about confidentiality or judgement.
- Workers might consider approaching property owners to establish a protocol for quick easy rentals with furnishings for women escaping violence.

Working With Child Custody Issues

- Most women report that they prefer not to work with MCFD because "they don't trust them". There are many reasons for this. For example, some women have signed voluntary care agreements for their children during or after leaving an abusive relationship. However, they are then told that the children will not be returned until the mother has demonstrated long-term sobriety. Some women may go back to their addiction, as this is another trauma/stressor on top of leaving a harmful situation. Women may want to sign an agreement to have their children stay in the home of a relative instead.
- Band welfare workers and counsellors are often very poorly paid and overworked. Often the band workers don't have a good understanding of women's safety issues. Women may be concerned that their children are unsafe in their current situation, but may also be afraid to seek help for their children, for fear that they will be removed. There are few foster homes, and if child welfare wants to place kids under kith and kin agreements with family members, there are not always healthy family members available. Some women do not want to connect with their band for services, as there is the perception that there isn't confidentiality and there are biases based on who is related to whom.

4.4.3 References, Resources And Further Reading

For more information on the Indian Act, go to the Justice Canada website: *http://lois.justice.gc.ca/en/showtdm/cs/I-5.*

For more information about intergenerational trauma go to the Aboriginal Healing Foundation website: *http;//www.ahf.ca*

Aboriginal Healing Foundation.1999. *Aboriginal Healing Foundation Program Handbook*, 2nd Edition. Ottawa: Aboriginal Healing Foundation.

For a discussion of links between colonization and racism and violence in Aboriginal communities, see Emma D. LaRocque. 1994 *Violence in Aboriginal Communities.* Ottawa: Health Canada 73-76.

Aboriginal Trauma Treatment Centres

Tsow–Tun le-lum Society in Lantzville, BC provides a three-week residential trauma recovery program. Participants must have three months clean time. See *www.tsowtunlelum.org.*

The First Nations House of Healing on Quadra Island provides gender-specific programs from nine days to three weeks long. Provide services free of charge if the client is registered under the Indian Act, which includes treatment services and a travel subsidy. Each program will create awareness of the legacy of residential school and its impacts to former students and their families. This will include addressing anger, healthy identity, living empowered, cultural and spiritual reconnection, communication skills, boundaries, self-care and healthy relationships. For more information see *www.intertribalhealth.ca* or email fnhh@intertribalhealth.ca or call 1-877-777-4842 for current programming.

Indian Residential School Survivors Society (IRSSS) provides support and general information regarding common experience settlement and support for residential school survivors and their families. Also provides assessment for counselling services for survivors and their children at the closest resource to the survivor's community. See *www.irsss.ca.*

Addiction Services

Association of BC First Nations Treatment Programs: Provides practical information about residential treatment centres in BC for First Nations people, but is not restricted to First Nations people. *www.firstnationstreatment.org*

Vancouver Island Health Authority: Information about mental health and addiction services. *www.viha.ca/mhas/resources.htm#links*

First Nations and Inuit Health Branch (FNIHB): Information regarding Non–Insured Health benefits such as travel and payment for residential treatment services and for short term crisis counselling. *www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnib-dgspni/index_e.html*

4.5 The Importance of Identity In Working With Métis Women

By Belinda Lacombe

4.5.1 Introduction

Terminology is important when working with a person who is a blend or a fusion of two cultures. As a Métis woman myself I understand the significance of my Métis label as one of pride and strength. Unfortunately, this is not the case for many of the Métis women who enter an anti-violence agency. They may have all sorts of negative preconceived notions of what it means to be Métis. They may not even recognize themselves as Métis.

4.5.2 Identity And Women

Women who can be called Métis can feel particularly vulnerable when they enter the office of an anti-violence worker. Their degree of vulnerability hinges on their acceptance of both parents' ancestry. Unfortunately, what I have seen more times than not is a denial of the Aboriginal side of themselves. There are many reasons for this: the Aboriginal parent might have terrible experiences with residential schools, racism and discrimination and therefore wants to protect their child from these experiences. They protect by keeping their ancestry a secret or creating a deep sense of shame by over-identifying with their white partner's family. In many Métis families the children who the Indian agent saw as Aboriginal were taken to residential schools and those children who were fair-skinned were allowed to stay with their parents. This has long-term repercussions.

Métis women may have learned that to acknowledge the Aboriginal side of who they are makes them less in the eyes of society or more likely to be discriminated against or victimized. They may have been told that Aboriginal people are all "drunks and bums" and believe these things. Essentially, they may carry a sense of hatred for a piece of themselves and worse yet, a very big secret. The problem with this denial of self is the unwillingness to look at the family history with the Indian Act, the unwillingness to share the family secret and most importantly the lack of a full self. The implication for trauma work with these women is that they cannot truly heal from trauma if they are caught up in secret keeping, denial of identity and shame around identity. This means that our work with them has to begin with creating safety so that identity can be addressed. Without this time consuming work, real healing may not occur.

The cultural genogram[1] is an excellent vehicle when working with women who believe they may be Métis. It provides an opportunity to ask them about family practices and where they think they originate. For example, a woman I worked with revealed during a session in which we were using a cultural genogram, that a distant relative told her that her abuse was due to the fact that her father (the abuser) was abused in a residential school for most of his young life, and was therefore really not accountable. Her relative tried to convince her that it would be best if she simply forgot about what happened to her and moved on with her life. Nobody,

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1 A cultural genogram is an adaptation of a family genogram that promotes exploration of cultural influences on an individual's family experience. See Hardy, K.V. and Laszloffy, T.A. 1995. The Cultural Genogram: Key to Training Culturally Competent Family Therapists. Journal of Marital and Family Therapy. 21(3): 227-37 for more information.

not even her mother, knew about her father's childhood experiences, and if she were to start digging around, the family's past would be revealed and with it this family's secret.

For many women who have been denied their Métis culture, simply learning about the history of Métis people and what a distinct and proud people they are can be very empowering. Their learning can help them explain some of the questions they have about their upbringing. For example, for the above mentioned woman, as she learned more about Métis culture she understood why her Dad was not interested in community involvement and socializing. He had no experience with the larger community because he grew up in a Métis family that was "its own community." He was not trying to deny her friends; he simply did not understand her need for outside involvement. Although he did not acknowledge his Métis self he continued to live a Métis way of life. This can be very confusing for a child. She always thought he was simply mean and did not care if she had any friends. This was very an important learning for her and it made her want to know more.

Fortunately, as anti-violence workers we have an opportunity to facilitate a positive image of Métis women. Bring examples of Métis women into your conversations with your client. Invite Métis women to talk in women's groups. They understand this unspoken invisibility. These things can be immensely powerful for Métis women who are beginning to connect to their identity.

4.5.3 References, Resources And Further Reading

Brown, J. 1983. Woman as Centre and Symbol in the Emergence of Métis Communities. *The Canadian Journal of Native Studies* 3: 1: 39–46.

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Carpenter, J. 1977. *Fifty Dollar Bride: Mary Rose Smith A Chronicle of Métis Life in the 19th Century*. Sidney: Gray's Publishing.

Culleton, B. 1983. *In Search of April Raintree.* Winnipeg: Pemmican Publications.

MacEwan, G. 1981. *Métis Makers of History*. Saskatoon: Western Producer Prairie Books.

Métis National Council of Women: *www.métiswomen.ca*

Turtle Island Productions: *www.turtle-island.com*

Van Kirk, S. 1983. What if Mama is an Indian: The Cultural Ambivalence of the Alexander Ross Family. In L H Thomas and J E Foster, eds. *The Developing West*. University of Alberta Press.

4.6 Safety Planning with Sex Workers

4.6.1 Introduction

Women who are sex workers are highly vulnerable to experiencing violence in their lives. Many live in a world of exploitation, judgment and stigma, and face multiple barriers to accessing support and health services. Their lives are often compounded by a number of factors, including poverty, homelessness, trauma (PTSD), substance use, racism, disability and having their children apprehended. As a result, survival sex workers are among the most marginalized and vulnerable population of women you may work with.

Survival sex workers also have incredible strength and courage in facing and enduring the conditions that brought them into the work and that continue to impact on their lives. Survival sex workers often face complex risks to their safety and struggle to trust when they have been offered little or no protection in the past. Establishing a trusting relationship is crucial but is likely to take time. Many survival sex workers have incredibly highly tuned safety strategies, so be sure to take their lead when discussing safety planning. In this section we have included specific information on sex work relevant to anti-violence work. We have also included a set of safety planning guidelines.

4.6.2 General Information On Sex Work

The following information is adapted from the *Network of Sex Work Projects Promoting Health and Human Rights:* www.nswp.org/nswp/introduction.html.

Background On Sex Work
Commercial sex takes place in many kinds of ways and involves many different types of people, many of whom are in no way stereotypical. People of various backgrounds sell sex and they do so for a broad range of reasons. These reasons often change over time. Some people sell sex as a full-time occupation, while others sell sex occasionally. Some people are willing sex workers and others are pressured to sell sex and others are sold for the purposes of selling sex. Commercial sex is an ancient and widespread phenomenon. Women, men and transgendered people sell sex all over the world and have done so forever. It is more useful to think about sex work as the sale of services and time rather than selling one's body.

There are plenty of reasons why people sell sex, the main reason being that people need to "make ends meet." Few people to whom all other options are open choose sex work. Most people choose sex work out of a limited range of choices. For some, sex work brings autonomy from oppressive families or partners or occupations. For others, sex work offers an escape from poverty or a way to secure material stability and privacy. For a very few it is the fulfillment of a fantasy or of a natural talent. For others it may simply be a question of chance. Not all or even most people who face pressure, poverty and very limited options become sex workers.

One of the most popular questions about sex work is "Why do people sell sex?" The obvious answer is "Because people buy sex." The sex industry is subject to the same economic rules as any other business or industry— demand drives supply. However, the factors that create demand for commercial sex reflect multiple realities. Clients seek sex workers for a variety of reasons. Some clients seek sexual services because they want to have sexual relations without emotional ties, or because they like the thrill of anonymous sex. Some like illicit or forbidden sex, because they want to perform sexual acts that their sexual partner does not approve of or cannot perform, or to fulfill sexual fantasies. Some look for the illusion of being loved by someone, others to prove their masculinity or power over someone else. Many clients seek sex workers to learn about sex, while others look for someone to talk to and keep them company. On the other hand, some perceive a commercial sexual transaction as the purchase of a body to which they can do whatever they like. Some think that by purchasing a sexual service, they also purchase the sex worker's right to say no.

Third Parties

Many other people are involved in commercial sex in addition to the sex workers and clients. These include business owners, bar tenders, cleaners, taxi drivers, maids, receptionists, touts, security staff, local vendors and many others. The people with whom sex workers share their private lives may also have a role in influencing the environment in which sex workers live and work. Note that the term "pimp" is not used in this section. It is unhelpful because it collapses too many of the "third parties" described above into one [stigmatized] category. This reduces the opportunity to understand the important and different influences that these actors may have. Most sex workers rely on the support of third parties in their work. Many third parties are crucial to the protection and safety of sex workers and to the provision of sex work itself. However, some third parties can and do exploit sex workers.

A good brothel owner is one who provides good working conditions and pay, just like any other good employers. There is nothing inherently exploitative about commercial sex, but its status and sex workers' lack of civil and industrial rights offer few mechanisms to limit the behaviour of bad employers. Relationships vary greatly between sex workers, their employers and other third parties, including even those defined as "traffickers". Slavery is at one end of the continuum and very good business arrangements are at the other.

Sex workers' personal relationships with family, friends, lovers and husbands also vary greatly. Some sex workers are forced to enter or remain in the industry by people with whom they have personal relationships, and others enjoy supportive relationships that can have a crucial role in their well being and safety. Sex workers' private sexual partners also affect sex workers' health. In places where most commercial sex is protected or non-penetrative, high sexually transmitted infection rates among sex workers have been attributed to their private sexual partners.

Local gangs and criminal groups often play a part of the sex industry. This can but does not necessarily lead to exploitation. They may provide protection from police and violence and provide other services that sex workers value. Stereotypes, simple labels and moralistic analyses can obscure the multiple realities within sex work.

Police

The relationship between sex workers and the police is varied. In some cases, police harass sex workers. Police can be the main source of violence towards sex workers. Some police officers extort money from sex workers in exchange for not arresting them. Police are also a major client group, and therefore engage in all types of client-sex worker relations. On the other hand, in many cases the police have an understanding of commercial sex and protect sex workers from criminal elements. Sometimes the police tolerate sex workers or commercial sex establishments in return for some information from sex workers about local criminals.

Sex workers, like other marginalized groups, are often reluctant to report assault to the police. Women in the sex trade may be reluctant to report because of:

- Perception by the public that assault is part of the risk of their lifestyle
- Their own, or others', negative experiences with police
- Mistrust of the system, a belief that the system will not respond
- Fear that they will not be believed
- Fear that they will be arrested if they have outstanding warrants
- Fear of retaliation by the assailant

At the same time, sex workers are far more vulnerable to physical and sexual assault than the general population. Recent cases involving Donald Bakker and Robert William Pickton have highlighted the incredible risks that sex workers face.

Some municipal police and RCMP detachments in BC, particularly in urban centres, have made efforts to build relationships of trust with sex workers. In 2007, the BC Association of Chiefs of Police accepted a proposal for implementing third party reporting procedures across the province. Third party reporting allows a victim of sexual assault to make a report to a third party, such as an anti-violence agency, who then passes that report on to police. Third party reports can be especially beneficial for sex workers, because of the considerations listed above. (The proposal was developed by the Community Coordination for Women's Safety Program; for more information see *Third Party Reporting: Access to the Criminal Justice System for Marginalized Victims of Sexual Assault* Available at www.endingviolence.org.)

Forms Of Sex Work

There are many types of sex work. Once again, diversity is the rule. Some sex workers look for quick transactions while others look for long-term clients. In some cases, sex work and domestic work are combined. There are reports of women who work as both maids and sex workers in the Middle East, as homes offer a good cover for illicit activities. Police do not usually enter homes and outsiders never enter without being invited. Similarly, sailors and truck drivers in some African locations typically hire a woman's services for a few days. Services include washing clothes, cooking, general domestic tasks and sexual services. In this scenario, sex is not a central part of the agreement.

There are specialized types of sex work. Some sex workers offer specialized services such as sado-masochism, domination and submission. These specialized services rely on role-playing and the fulfillment of fantasies and fetishes. They do not necessarily involve any sort of penetrative sex. Some sex workers specialize in providing sexual services to people with disabilities. They are called surrogates and their work is a mix of sex work and sex therapy. These services involve specialized knowledge of safe practices and techniques.

Some people practice sex work in an indirect form. They may be entertainment workers (strip-tease dancers, belly dancers, go-go dancers, karaoke singers) who may engage in sexual transactions occasionally. Such transactions do not necessarily involve purely sex or penetrative sex. There is a whole range of sexual activities that differ greatly from straightforward sex.

Workplaces And Safety

Different sex work venues include streets, brothels, bars, saunas, massage parlours and other settings. Male sex workers also operate in resorts, gay bars and clubs, cinemas, car parks and cruising areas for gay men like parks, swimming pools, and public toilets.

> Sex workers' safety in the workplace is determined by a variety of factors. These include quality of lighting, the presence of support staff or other sex workers, clean facilities, access to water, safe sex equipment and accessories such as water-based lubricants.

The relationship between being a resource-rich sex worker and safety and being a poor, low-priced sex worker and safety is complex. An escort who sees her clients in a five-star hotel is not necessarily safer than a brothel worker, as she is more vulnerable to violence from clients due to her physical isolation. However, an escort working in that setting has more negotiating power with her client as she is accorded more status in the industry overall and often clients are interested in being repeat clients. Women who work in relatively low paid sex work in truck stop bars have some safety, because there are many other sex workers around, they are on their own territory, and bar tenders offer security to some extent. Survival sex workers, however, may be particularly unsafe as they most often work in very isolated areas (industrial zones, dimly lit areas, on the street) and most often are working completely alone. Survival sex work has become increasingly competitive as women's' economic safety nets deteriorate, resulting in less cohesion among workers and more isolation in the work. In addition, a survival sex worker has the least negotiating power with a client and may be sought out as a target for violence.

Avoiding violence is often an important consideration for sex workers when they steer men towards different places to have sex and different sex acts and positions. More experienced sex workers often share stories and tips about which types of sex minimize the risk of violence in particular settings. For example, sitting on top of the man during sex gives more control than being under him. Scarves, "pony tails" and jewellery that can be used to trap or strangle a sex worker should be avoided. If a man is drunk, it is to the sex worker's advantage to have calming strategies.

4.6.3 Safety Planning Guidelines

The guidance below is focused on safety when undertaking sex work and has been taken from http://www.livingincommunity.ca/toolkit/ASWpage2.html_with some minor adaptations and changes.

General Tips To Keep Us Safe

- Try not to work when you are high or drunk as you may be more vulnerable to abuse or not be able to respond as quickly to an escalating situation.
- Wear shoes in which you can run, or that you can slip off easily.
- Do not wear anything around your neck that a client can use to strangle or drag you such as necklaces, scarves, etc.
- If possible carry a cell phone. You can call yourself and leave a message with a description or text the license plate to a friend. Even if it does not work or is out of minutes, carry it with you in plain view, as a client may be less likely to take a chance.
- Work with friends if possible. If you have to work alone, be creative and carry a piece of chalk with you to write down the license plate of your next client on the sidewalk or wall where you are standing. Always casually tell a client you have been seen leaving in their car and are expected back at a certain time.

- Carry a whistle. Some prefer to carry devices that can be used to protect themselves such as mace. However, it has been proven that such things can be turned against you at any given time. A whistle is safe, small, compact, legal and loud.
- Be extremely careful on the street.

Observe The Client
- Listen to his voice and observe body language.
- Listen to your intuition—if it does not feel right, there is a good chance it is not.
- Are they high? Are they drunk? Are you prepared to deal with them? Always ask yourself these questions.

Entering A Client's Vehicle
- Make sure the client is alone. More than one person increases your risks.
- Do a full circle around the car. Get the license plate number.
- Check behind the back seat to make sure that no one is hiding.
- Always check door handles before you get in to make sure they work.
- Make sure you know how to unlock the door before entering car.
- Try to avoid vans, pickups, and SUVs, especially with tinted windows.

Going Somewhere
- Unless it is a regular, avoid bridges, tunnels and dimly lit unfamiliar places.
- Pick your own parking spots and hotels.
- Check the address. If the client says they are taking you to one place, but pulls up to another, this may not be all they are lying about.
- Do not enter a room if there is more than one person. If others show up, leave immediately.
- When in a car or in a room, keep an eye on the exit at all times and do not let the customer block your access to it.
- It is safer for you to bring a client to your house and hide a friend in the closet than it is for you to go to the client's house and have his friend hiding in the closet.

4.6.4 References, Resources And Further Reading

Community Coordination for Women's Safety. 2007. *Third Party Reporting: Access to the Justice System for Marginalized Victims of Sexual Assault.* Available at *www.endingviolence.org.*

The *Community Initiative for Health and Safety* (CIHS) is derived from the two-year Living in Community Project that was conducted in Vancouver, BC. This project is a collaboration of community and government organizations, including peer-based groups formed by current and former sex workers (otherwise known as prostitutes or hookers), neighbourhood houses, community policing centers, business improvement associations, the City of Vancouver, Vancouver Police Department, Vancouver Coastal Health and the Vancouver Agreement.
CIHS website at *http://www.livingincommunity.ca/toolkit/ASWpage2.html.*
Please note: This website includes a list of organizations that support sex workers.

Farley, M. 2003. *Prostitution, trafficking and traumatic stress.* New York: The Haworth Press, Inc.

Network of Sex Work Projects Promoting Health and Human Rights. www.nswp.org/nswp/introduction.html.

4.7 Working With Women With FASD: An Emphasis on Safety Planning

BY TESSA PARKES

In compiling this resource we were not able to find specific materials on *safety planning* with women with FASD. Indeed, there is very little research, literature or practical guidance that deals with women with FASD specifically, or includes a gendered perspective. There are, however, a number of sources that outline strategies to consider when supporting adults with FASD. This information can be applied and adapted to working with individual women who use our anti-violence services.

4.7.1 What Is Fetal Alcohol Spectrum Disorder?

FASD is an umbrella term used to describe a continuum of effects that result from maternal alcohol use during pregnancy. FASD is a brain-based physical disability with behavioural symptoms, and affects people in different ways. . Many of the disabilities associated with FASD are hard to discern by others, particularly those that do not know the person, such as problems with memory, reasoning and judgment. For many affected people there can be a problem with lack of social boundaries and difficulty in reading social cues and understanding the link between actions and consequences. Unlike other better understood disabilities affecting the brain, such as Down Syndrome, FASD is often invisible. It may seem that a person with FASD is being uncooperative, resistant, non-compliant or unmotivated, when they just do not understand what they are supposed to be doing. They may be talkative, sociable and engaging, leading others to assume they can manage their lives the same as a person without this disability. Another key reason why people with FASD are often viewed as uncooperative or lazy is because of their difficulties with receptive communication. That is, they may be able to speak well but have difficulties understanding. This creates additional social vulnerability.

Definitions
Many terms have been used to describe abnormalities that can be associated with prenatal exposure to alcohol. Fetal Alcohol Spectrum Disorder (FASD) is a non-diagnostic term that covers the full range of birth defects and disabilities associated with prenatal alcohol exposure. Since 1996, the following four diagnostic terms have been accepted.

1. Fetal Alcohol Syndrome (FAS)
There are three criteria used to describe the effects of prenatal alcohol exposure in order to make a diagnosis of FAS: a pattern of facial abnormalities (may include unusually small eyes, smooth upper lip, etc; see resources below for more information), growth deficiencies and central nervous system impairment. The central nervous system impairment many include structural abnormalities of the brain; neurological problems such as impaired motor skills, poor coordination and visual problems; and behavioural and/or cognitive problems such as mental handicap, learning difficulties, poor impulse control, problems in social perception, problems with receptive communication, and problems in memory, attention, reasoning and judgment.

2. Partial FAS (PFAS)

Partial FAS is the term used to describe those individuals born with evidence of some of the characteristic facial abnormalities associated with FAS and evidence of one other component (growth deficiency or central nervous system impairment) when it is known that there was significant prenatal exposure.

3. Alcohol Related Neurodevelopmental Disorder (ARND)

Alcohol Related Neurodevelopmental disorder describes the presence of the structural or neurological brain abnormalities and/or the behavioural and cognitive problems associated with FAS, without the characteristic facial or growth abnormalities, when it is known that there was significant prenatal exposure.

4. Alcohol Related Birth Defects (ARBD)

Individuals born to mothers who drank heavily in pregnancy may also have congenital birth defects such as skeletal abnormalities, heart defects, cleft palate and other craniofacial abnormalities, kidney and other internal organ problems and vision and hearing problems. These are known as Alcohol-Related Birth Defects (from Poole and Loock 2005).

4.7.2 Challenges That A Woman With FASD May Have To Deal With

The primary disabilities associated with the diagnosis of FASD come under the area of cognitive processing. The impact these cognitive processing problems have on an individual's life tend to be most noticeable in the following areas:

Difficulty with:
- Understanding cause and effect
- Understanding consequences of actions
- **Learning**—the ability to learn can be compromised so that even simple tasks can need constant repetition over a sustained length of time.
- **Generalization**—taking information from one situation and applying it to another.
- **Decision making and judgment**—relatively simple decision-making and judgment tasks can be overwhelming for individuals who have problems with organization, working memory, sequencing, abstract thought, goal directed behaviour, field-dependency and impulse control.
- **Communication**—receptive and expressive language skills can be compromised—content of speech may be confused and not to the point—receptive language is often particularly compromised.
- **Information Processing**—may fluctuate from day to day and within a given day, due to familiarity with specific information, competing demands, structure of the environment, emotional state of the individual and/or degree of fatigue.
- **Emotional Regulation**—a person may go from being calm to agitated without an apparent explanation. This can be combined with poor inhibition and confusion in the interpretation of incoming sensations. Individuals can be easily overwhelmed by relatively commonplace events/circumstances and react to everyday situations with emotional volatility.
- Managing money
- Paying attention, staying still and perseverance.

Disabilities associated with FASD come under the area of cognitive processing.

If you are working with a woman you think may have cognitive or developmental challenges, you may want to consider the possibility that her struggles are connected to FASD. Here is a list of "ways of being" commonly shared by people with FASD:

Memory
- Memory may skip from day to day.
- May need to hear something many times before it can be remembered— if ever.

Decisions
- Thinks in black and white—doesn't understand grey.
- May have trouble making decisions and understanding outcomes of those decisions.
- May have difficulty understanding responsibility and taking responsibility for their actions.

People skills
- May have trouble reading other people's signals or body language.
- May have difficulty making judgments about other people, particularly difficulties recognizing or predicting when people may be taking advantage of them.
- May have different boundaries than others:
- May take things that don't belong to them without viewing it as stealing
- May touch others in a way that is crossing boundaries.

Time and place
- May become upset when routines are changed.
- May have trouble understanding "yesterday" and "tomorrow" or "before" and "after."

Communication
- May talk a lot but say little—their talk may sound like they are understanding you, but often they will not.
- May take things literally and not understand the double meaning of some words.

As a result of all the dimensions mentioned above, plus impulsivity and difficulties in controlling anger, women who live with FASD are at far greater risk of experiencing violence, trauma, mental health and substance use problems than women without these disabilities.

Obviously some of the points listed above have critically important implications for women living in violent relationships and for safety planning, which will be addressed later in this section.

> **C**hallenges with goal directed behaviour, organizational ability, literacy skills, and communication can make everyday living overwhelming.

4.7.3 Guidance On Supporting A Woman With FASD

Most adults with FASD are not diagnosed: a diagnosis is often difficult to make in adulthood. If you work with a woman who is having difficulties in the areas that have been described above, you could think about using some of the strategies outlined below, whether the woman has been assessed as having FASD or not. However, when using these strategies please keep in mind that a woman with FASD cannot change her disability. The strategies that are outlined below are designed to sensitize us to many of the potential difficulties a woman may have and what may help if we are able to adapt *our* ways of working to better suit her needs.

There is literature that describes the importance of people with FASD being connected with someone who can act as their "external brain" (Buxton 2004). A person who provides support as an external brain, or "external hard drive," is someone who assists in a friendly and nurturing way, providing help in the form of cues to support the person with many aspects of their life. These cues can be things like verbal reminders, help constructing lists and, if necessary, help in creating an environment with structure and boundaries. The types and amount of external brain support will be dependent on the particular needs of the individual.

Work by Sharon Hume and Associates (2006) indicates, however, that when external supports are withdrawn, it is unlikely that the person with FASD will be able to maintain the activities or behaviour that they were able to do when the supports were in place. This work evaluated a project that provided one-to-one support to women and girls with FASD to improve their self-esteem and build on their strengths in order to increase their safety. While the evaluation found that some participants had improved personal safety, it also found that without ongoing support the women could not carry on with the activities, leaving them vulnerable to further risks. *The researchers concluded that "environmental accommodations and routines established with the assistance of others need to be reinforced on an ongoing basis: reminders, accompaniment, transportation, and modeling of appropriate social skills are examples of useful environmental accommodations."*

For workers in the anti-violence field, it may well not be possible to work with a woman over a long period of time providing this level of support and guidance. We must therefore try to do what we can, in the time we do have, to help a woman to create a wider support network for herself that is made up of positive and safe others who can help on a longer-term basis. She may already have this, but if she is in a violent relationship the chances are that she will not have such a support network.

Many of the disabilities associated with FASD are hard to discern by others, particularly those that do not know the person, such as problems with memory, reasoning and judgment.

SPECIALIZED KNOWLEDGE SECTION 4

4.7.4 Strategies To Use When Working With Women With FASD

The table below identifies some challenges a woman with FASD may have and ideas you could try in your role as advocate and counsellor. Remember: many of the strategies listed will only really be effective when used on a 24-hour basis. Our purpose in listing them here is to help you think creatively about a woman's potential support needs and ways of changing your ways of working to make them more inclusive and appropriate.

CARES: The Basics Of Working With Someone Affected With FASD

CUES	• Use visual and voice cues • Give simple, clear and concrete instruction • Avoid list of steps that may be difficult to remember, give no more than one step at a time, and only when the individual is about to undertake the activity (may be impossible if your work with a woman is office based) • Focus on what is happening now • Help with transition
ATTITUDE	• Try differently not harder • Drop your own assumptions and get curious • Look for strengths • Check your goals and expectations as you learn more about this person • Work within your agency to develop and implement a consistent care plan. Discuss and document results with your work team and with your client
REPETITION	• Repeat yourself using the same words each time • Probe for understanding—have them show how they understand what you've said • Keep mood calm and distraction levels as low as possible • Provide reminder tools and aids as needed • Keep consistent
ENVIRONMENT	• Keep safe spots where someone can go to calm down • Create special evacuation and safety procedures (alarms can be over-stimulating) • Help community members to understand
STRUCTURE AND SUPERVISION	• Be consistent • Limit choices and the need for decision-making • Keep to routines as much as possible • Give immediate feedback

Adapted from the *We Cares* resource kit by Anne Wright and Associates (2004).

4.7.5 Safety Planning With Women With FASD

Safety planning requires cognitive processing skills that are difficult for women with FASD, such as goal directed thought, integration and synthesis of information, understanding cause and effect, organizational skills, and reading cues and signals from others or from situations. Having difficulties in some or all of these areas may seriously impact a woman's ability to keep herself safe.

Remember—goals designed to help one woman may do nothing to help another. It is vitally important to know a woman's individual strengths and difficulties.

The level of support that each woman will need will vary depending on a number of factors, including her own challenges and strengths, resources, supports and support needs. Your work will be:

- To identify key supports and resources that a woman can draw upon. Find out who is part of her support circle. If a woman has a support network this will be a huge benefit in the safety planning process. If not, it will be important to work with her to build her support community and expand her own safety net. Integrated case management and care planning can make a huge difference to safety for women with FASD.
- To involve her existing support network in the safety planning process.
- To spend time with her talking through her unique situation and exploring together the risks and protective factors in her life. It is likely that this process, as in the case of women with mental health and/or substance use concerns, will require focused time and energy because of the added complexity of the task.

During periods of transition, support needs are likely to be at their highest.

The following suggestions can be used to help guide your work around safety assessments and planning with women who struggle with cognitive and development disabilities, including FASD.

Attitude—Understand yourself in this work
- Shift your own attitude so that you drop your assumptions about a woman.
- Be patient and relaxed in your approach.
- Even more than usual individualize the support you provide.
- A woman may be more likely to agree and comply with your ideas and suggestions to please you or because she is lacking in confidence or because she does not understand what you want her to do. Be wary of this and of leading a woman to decisions that are not hers.
- Look for successes and wherever possible recognize them with her.

Find ways to give the message that the woman with FASD has strengths and is capable of making good choices.

Communication
- Avoid technical terms.
- Avoid asking questions you already know the answers to.
- Don't speak too fast.
- Help the woman stay on track by rephrasing questions and providing structure to the subject you are discussing.
- A woman may be very literal in her communication, so avoid words or phrases with double meanings.

- Don't interrupt the woman.
- Ask the woman to reflect back what she has heard to check she has understood you.
- Limit the amount of information presented to her at once.

Structure your work together
- **Routine is important—**keep to routines with appointments as far as possible.
- **Provide gentle reminders—**be creative in thinking about reminder tools and aids for her that will not create more dangers.
- **Keep sessions short and focused—**ask her to tell you (and watch for) times when she is struggling to concentrate.
- Go over the focus of the work of each session before and after each session to help memory retention.

Help women to identify unsafe situations
- Give her opportunities to talk through situations and help her to make sense of them by providing feedback, emphasizing the consequences or potential consequences of situations.
- Where possible (if she can generalize and anticipate) help her to recognize similar situations and the warning cues she may get and think through strategies to help her to know when to act on these warning signs.
- Help her to recognize her own warning signs that things are escalating.
- Help her to recognize her signs of stress and try to prevent sensory overload.
- Create a list of step-by-step instructions to guide her on dealing with unsafe situations (provided this does not place her in danger). Perhaps use visuals: pictures of people who are unsafe in her life, draw rooms of her home and have pictures showing her going to a safer room when she is being assaulted. Pictures of her taking a cell phone with her when she leaves home, etc. Remember that she may not be able to retain this information outside of your work together and particularly in very stressful situations of violence.

Help with decision-making
- People with FASD can be very linear in their decision-making, which makes it difficult for them to choose from a variety of options. Although this is hard to do in safety planning, limit choices and the need for decision-making—help her make a simple and doable plan that she can practice.
- Identify consequences together, as far as this is ever possible in situations where she has little control.
- Allow extra time for talking through the process.
- Provide reminders of important decisions during all sessions you have together.
- Talk about and model the steps she can take.
- Talk about and plan for transitions as these can be particularly challenging times.

> ❞Safety planning should be ongoing and repetitive because practicing is important for some people. The use of role plays and visual models, as well as reviewing problem-solving strategies addressing different scenarios, will help generalize safe thinking" (Hoog 2003).

Help with skill building
- Build skills in the place where the skills will be used. Where at all possible use a three step process:
    - **Modelling—**show by doing yourself.
    - **Practice with guidance—**explain how this will help and encourage her to try. Give immediate feedback while she is trying. Be prepared to do this over and over.
    - **Reinforcement of behaviour—**reinforce the new skill and the woman's ability to use it.
- Rehearse, rehearse, rehearse.
- Break new skills and concepts into very simple steps.

Helping to build and strengthen supports
- Develop a history of supports—figure out what worked and what didn't and what supports are still around today—search for any new supports that may be available.
- Involve a woman's support people in the safety planning discussions and in any plans of action and interventions.
- Accompany her to other professional appointments and if necessary explain, with her, how FASD or cognitive disability affects her and what you have both found helpful in terms of meeting her support needs.
- Explain what you know to other colleagues and help your team members see other ways of working.

Conclusion

Women with FASD are one of the most vulnerable groups of women in our society. Women with FASD are vulnerable to abuse and manipulation and to becoming involved in situations that are very hazardous to their physical, emotional, mental and spiritual wellbeing. There are also few services that support women with FASD with their extra needs as adults. There is therefore a considerable gap between the needs of women with FASD and the supports and resources available to meet these needs.

Helping a woman with assessing her risks and dangers and then helping her with safety planning is essential work that is very challenging for her and her supporters. This said, there are many possibilities for making a difference in women's lives if we are informed about the various accommodations that can be used to underpin our work together. Changing our own expectations would be a good place to start. Helping her create her own long-term support network could have a huge impact on her life, though the practical challenges of doing this within our time and resource constraints must also be fully acknowledged. The advice in the FASD world of "try differently not harder," is a reminder that we will need to think and act differently in order to effectively support a woman with FASD: get curious about how a woman understands the world, about her way of being in the world, and be creative and experimental in your responses to her. Our core values in anti-violence advocacy, support and counselling, of focusing on a woman's safety, survival, strengths and self worth, will be our main support in this work.

4.7.6 References, Resources And Further Reading

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Malbin, D. 1993. *Fetal Alcohol Syndrome/Fetal Alcohol Effects: Strategies for Professionals.* Centre City: Minnesota: Hazelden Educational Materials.

Poole, N. and C. Loock, 2005. *BCRCP Guidelines for Alcohol Use in the Perinatal Period and Fetal Alcohol Spectrum Disorder.* Vancouver: BC Reproductive Care Program.

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Streissguth, A and Kanter, J. 1997. *The Challenges of Fetal Alcohol Syndrome: Overcoming secondary disabilities.* Seattle and London: University of Washington Press.

United Way of Calgary and Area. 2004. *New Perspectives on Transitions and Fetal Alcohol Spectrum Disorders.* United Way of Calgary and Area.

VON Canada. 2005. *Let's talk FASD: Parent driven strategies for caring for children with FASD.* Ottawa: VON Canada National Office.

National Resources
Canadian Centre on Substance Abuse
www.ccsa.ca
1-800-559-4514 (toll free in Canada)
The CCSA provides information on FAS over the phone or by email. There is a searchable database at *www.ccsa.ca/fas.* There is also a section of recent resources on FASD found under the TOPICS section on the main page and a section on women's substance use and treatment under the TOPICS section as well.

Centre for Addiction and Mental Health (CAMH)
www.camh.net
Tel: 416-535-8501
With the backup of an extensive library of resources on the topics of Alcohol and Pregnancy and FAS, the CAMH library reference service responds to requests for information and referrals from professionals, students and the general public.

Website Resources
FASD Connections
www.fasdconnections.ca
This website has a mission to build a community where adolescents and adults with FASD are included and encouraged and their desire and potential are supported. It is an excellent resource that contains many helpful resources relevant to working with adults with FASD including sections on critical issues around FASD, a section on perspectives of those with FASD, sections on op coming events, a forum, and sections with recent articles and resources that are easy to download. The *What's New* section includes resources on women and violence, substance use, mental health, pregnancy and sex work.

Fetal Alcohol Syndrome Consultation, Education and Training Services, Inc.
http://www.fascets.org/index.html
"Services available through FASCETS are designed to increase understanding, build on strengths, expand options for developing effective parenting and professional techniques, enhance existing programs and support the development of new programs. Short term goals include increased effectiveness, reduced frustration, and attainment of improved outcomes, including burnout prevention in professionals. The long term goal

of this work is to contribute to the prevention of FASD. FASCETS supports the development of a family-centered, community-based, multidisciplinary continuum of care. This collaborative design has been found to be effective in enhancing communication among parents and professionals for their mutual benefit."

Healthy Choices in Pregnancy   *www.hcip-bc.org*
This BC based website offers extensive links to free resources on preventing alcohol use in pregnancy that violence workers may be interested in sharing with women accessing services.

4.8 Challenging Our Assumptions: Working With Women's Anger and Use of Violence

By Cathy Welch

In this section, we address the issue of women's anger and use of violence. As well, we look at some ways of assisting women to address angry and/or aggressive behaviour.

We will:

- review our understanding of women's relationship with anger, hostility and aggression;
- consider the connections between women's expression of anger and violence with experiences of trauma, mental health and substance use;
- explore women's use of violence; and
- examine various strategies for working with women to transform hostile and violent behaviour into more positive outcomes.

In order to effectively work with women's anger and use of violence, we must explore our own relationship with anger and violence—our own anger and violence as well as other people's. Interspersed throughout this section are some reflective questions to consider as preparation for engaging with clients in this very challenging work (see also Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective).

Some questions to ask ourselves:

- **What are the norms of expressing anger in my culture? How does that differ for women and men?**
- **What did I learn about anger and how to express anger growing up? What did I learn about women's expression of anger and violence growing up?**
- **What are my personal beliefs about anger and the expression of anger?**

4.8.1 Thinking About Anger

Anger is an emotion that warns us that something is wrong. It can be that we are being hurt or threatened, that our rights are being violated, that our needs are not adequately being met, or that we are giving too much (Lerner 1997). We have anger to protect us. It allows us to fight back when we need to defend ourselves (or others) from threat to our well-being or to fight for something that is personally important. It motivates us to change, to take action. In and of itself, anger is an adaptive, protective and life-preserving emotion. It is simply one feeling among many.

Anger can have both positive and negative consequences. The key point here is that it is the way that we respond to and express our feelings of anger that determine the outcome. Anger that is inappropriately acted upon or expressed has enormous negative costs on our emotional, mental, physical and spiritual well being. The

constructive release of anger is healthy and can result in positive outcomes. However, the healthy, respectful expression of anger doesn't necessarily come naturally. It is a skill that has to be learned and refined.

Anger is a natural and mostly automatic response to physical or emotional pain. Pain alone is not enough to cause anger, but when pain is combined with some anger-triggering thoughts, we feel anger. Thoughts that can trigger anger include personal assessments, assumptions, evaluations or interpretations of situations that makes us think that someone else or something is attempting (consciously or not) to hurt us. As well, anger is a defensive emotion to protect us from feelings of grief, sorrow, or fear embedded in the pain.

> **W**hat is my relationship to my own feelings of anger? How do I express my anger?

4.8.2 Differentiating Among Anger, Hostility And Aggression

Anger, hostility and aggression are often mistakenly considered to be one and the same. It is important to distinguish the ways in which they differ:

- Anger is an emotion. It is normal and appropriate to feel angry in response to some situations and/or people. The respectful (to ourselves and others) expression of anger is a meaningful way to inform others about the impact of their behaviour or to express one's personal limits, values, and boundaries.
- Hostility is a pervasive attitude that contributes to the violation of another person's rights, values, or boundaries. It can include brooding about perceived or real injustices as well as ways that one can get even. Hostility embodies feelings of powerlessness and can often lead to aggression or withdrawal as a means to punish.
- Aggression can be defined as a behaviour intended to physically or emotionally harm others, to pay back real or imagined wrongs. Aggression often results in disrespect for oneself and the other person and creates distance between the two people.

> **W**hat is my experience of another person's anger, hostility and aggression? How do I respond to others' expression of anger?
> Have I ever felt feelings of hostility? In what context did I feel these feelings? What were the origins of these feelings?
> Have I ever felt feelings/thoughts of aggression? What was that like? Have I ever acted on these feelings/thoughts?

4.8.3 Women, Anger And Aggression

Rage corrodes our trust that anything good can occur. Something has happened to hope. And behind the loss of hope is usually anger; behind anger, pain; behind pain, usually torture of one sort or another, sometimes recent, but more often from long ago (Estes 1992).

> **W**hat happens for me when I witness women's anger? What comes up when I think of women being violent? What am I afraid will happen?

Women's relationship with anger is complex. Women hold and express anger differently than men do. The outward expression of anger is not socially sanctioned in women, as it is in men. We have been socialized not to show or even be aware of our anger (Lerner 1997). We are taught to suppress our anger, to hold it in, to ignore it. When we are cut off from feeling or recognizing anger we are cut off from our capacity to fully engage or experience all of our being.

A woman who outwardly expresses her anger is feared in our society; we hold very powerful taboos against women feeling and expressing anger. Angry women are discounted, disapproved of and often pathologized. Historically, angry women have often been labelled as having borderline personality disorder. In popular culture women who use violence are generally seen as inadequate, unnaturally masculine, sick, evil or mentally disturbed.

In her book *Men, Women and Aggression,* Anne Campbell (1993) argues that aggression in men is "a means of exerting control over other people when they feel the need to reclaim power or self-esteem". She suggests that women's use of aggression is in response to "a temporary loss of control caused by overwhelming pressure and resulting in guilt".

Campbell proposes that the expression of aggression in women follows a four-step process:
1) control of initial anger—where the anger is felt and is contained;
2) through periods of crying or argument where the anger may be released and relieved if the situation improves;
3) physical aggression results from the continued and increasing tension (frustration) resulting in an explosion which acts as a means of release; and
4) the final stage is one of guilt or embarrassment at the outburst.

She suggests that the capacity for empathy is one of the main explanations for feelings of guilt following a physical outburst.

Lerner (1997) and Campbell (1993) acknowledge that there is a wide variation in how aggression is expressed and experienced within genders. They suggest that such factors as social conditioning, personality, upbringing and personal experience contribute to the greater or lesser propensity to experience anger and act aggressively. As well, cultural attitudes towards the expression of anger and aggression, and experiences of oppression—racism, classism, homophobia, etc—and violence, contribute to feelings of anger and the choices that women make in acting on those feelings.

How do the positive and negative effects of expressing my anger affect me—physically, emotionally, spiritually and mentally?

4.8.4 Mental Health, Anger And Violence

"Gender plays a significant role in mental health issues. For example, over 70 percent of people diagnosed with borderline personality disorder (BPD) are women. Those diagnosed as 'borderlines' have been stigmatized as being difficult to work with and treatment-resistant (meaning that they don't respond well to therapeutic interventions).

Key symptoms of borderline that many mental health professionals found so unpalatable were responses of emotional lability [rapidly changing emotions] and profound mistrust and anger expressed in what have been considered to be manipulative and aggressive ways.

There is now much greater awareness that many of the women who have been considered borderline are in fact experiencing complex posttraumatic stress responses" (Haskell 2003).

As discussed in the section Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective, popular culture and the media depict people with mental health issues as exceptionally angry and violent. Yet there is little evidence to substantiate this perception. Women who have mental health issues are not necessarily angry or violent. If a woman is angry, her anger may not be a consequence of her mental health issue, but may stem instead from other aspects of her experience. As well, she may be angry but her anger may never escalate into aggressive violent behaviour.

Given our strong cultural taboos against women's expression of anger and particularly violent behaviour, women who do express their anger are more likely to come to the attention of the justice and/or mental health system. A woman who is acting out her anger may be more likely to be medicated and diagnosed than a woman who culturally "passes" in her expression of anger. The following are several examples of women's experiences with the mental health system, criminal justice system or both as a result of their expression of anger or violence. In the first two cases, details have been changed to protect their identities and to preserve confidentiality. As you think about these women, ask yourself, what assumptions do I make about these women based on their mental health diagnoses?

Case #1
A Caucasian woman in her mid 40s is sexually assaulted by her brother-in-law. Her general demeanour is agitated, angry, easily reactive, belligerent and distrustful. The incident occurred when her brother-in-law came to her house one evening. He had been drinking. She invited him in, they talked and she offered him the couch for the night. She was awakened a couple of hours later with him on top of her, and a pillow covering her face. She struggled for some time but wasn't able to get free. The commotion eventually woke her adolescent children. Her daughter phoned the police. When the police arrive the woman is hysterical, alternating between tearful outbursts and anger. She can barely give the constable a coherent story of what happened. When he suggests she go to the hospital, she becomes very agitated and angry, yelling and swearing and refusing to go.

Several years prior to the assault, this woman was diagnosed as borderline personality disorder following an incident where her husband held her and her children (then quite small) hostage for almost twelve hours, terrorizing them with knives and a gun before he shot himself. At that time, she was so agitated and angry that she was put into a locked room on the psychiatric unit and sedated. She remained heavily medicated the entire time she was in the hospital. The belief was that it was best to keep her medicated and to not make reference to her experience. When she was released she was prescribed Ativan, Prozac and Clonazepam. Between these two incidents she received little support or counselling because she was considered borderline. She did, however, continue to be prescribed the same medications. Her mood is often agitated, easily flares into rage, and she remains distrustful of people.

Charges are laid in the sexual assault case and eventually she will have to testify in court. What kinds of supports would this woman need to be effective on the witness stand? If you were her worker, how would you

work with her? What are the challenges? Does her anger affect the way you would work with her? If she was angry as a result of the assault, and not labelled borderline, would that make a difference?

Case #2

An Aboriginal lesbian is diagnosed as bipolar because she experiences extreme mood swings and is often loud, and easily agitated. On one occasion she violently resisted being handcuffed when the police were requested to assist the mental health emergency response team in taking her to the hospital against her will, following what was believed to be an attempted suicide. Over the years, she has been given a multitude of medications, none that seem to really work. She struggles with deep depressions alternating with periods of hyperactivity, racing thoughts and angry outbursts. She has a history of physical violence and sexual abuse in childhood, in addition to extreme psychological abuse. She began drinking as a teenager when her older sister took her to a party where she was raped by her sister's boyfriend and his friend. Every year, as the anniversary of the rape approaches, she becomes agitated, restless and increasingly angry, sometimes violent—either towards herself or her property. The only time she is violent to others is when someone tries to restrain her—most often the police. These outbursts are considered to be manic episodes.

These women are given mental health diagnoses based predominantly on their behaviours (irritability, angry outbursts, and general unwillingness to co-operate with the system). The events, historical and recent, that led up to their behaviour tend to be ignored, discounted or rendered irrelevant. What is important here is that, regardless of what mental health diagnosis or diagnoses a person is given, if experiences of trauma are not taken into consideration and made a focus of healing, the potential for change may be significantly compromised.

Colin Ross (2000) suggests that experiences of trauma, especially early childhood trauma, are the most important contributing factor in all mental illnesses. This is not to say that all mental health issues are trauma based, but many are, and life experience is often the cause for psychiatric disorders (Ross and Pam 1995).

4.8.5 Women And Violent Crime

How do you think a woman's race, class, sexual orientation and/or gender expression might play a role in how she is perceived if she verbally expresses her anger? What if she is violent? How might systems respond?

Violent crime is more often committed by men than by women. According to 1991 Statistics Canada figures, 88% of all those charged with violent crime were men, 12% were women. Women are more likely to be charged with minor assaults, property crime and fraud. Eighty percent of the women in prison have been convicted of economic related offences (Elizabeth Fry Society 2007). When women do commit violent crimes, such as murder, they are often sensationalized and demonized by the media. Women who commit violent crime generally show high rates of violent childhood experiences of sexual abuse, extending over a long period of time and with multiple perpetrators. Often the violence these women experience extends well into adult life. Incarcerated women also face added factors of racism, classism, poverty, lack of education (average level of education amongst women in federal prisons is grade nine), marginalization and isolation (Elizabeth Fry Society 2007).

Case #3

Yvonne Johnson told her story in the book *Stolen Life: The Journey of a Cree Woman*, which she co-authored with Rudy Wiebe (1998). Johnson tells a story of a life full of violence, stemming from a very early age, sexual and physical violence by multiple perpetrators, racism, poverty, and growing up in an alcoholic family. Her adult life is a continuation of the violence of her youth. She is one of four people convicted of the murder of Chuck Skwarok in 1989. She believed that he was a child molester and a threat to her children. While intoxicated, Johnson participated in his torture and beating. Johnson was so fearful that her children might be abused that she would do anything to protect them. She was sentenced to life in prison, a much more severe sentence than her male co-accuseds received.

Case #4

Aileen Wuornos was convicted of the murders of six men and was sentenced to death and executed in Florida. The movie *Monster* is based on her life. Wuornos was a lesbian, white, poor, abandoned and abused as a child, raped, impregnated and forced to give up her child as a teenager. As an adult she was isolated, addicted to alcohol and drugs and engaged in survival sex to feed and house herself and her lover. She experienced a very violent rape by a trick, and after that when tricks got potentially violent, controlling, etc. she experienced flashbacks and killed them. Her trauma background was regarded as irrelevant in court. She was convicted and put to death. In the course of the court process she was diagnosed as a borderline personality and her behaviour described as psychopathic.

In general, crime rates are declining, but the numbers of women being incarcerated is growing. Worldwide, there is a trend for women to be the fastest growing prison population. This is especially true for young women of colour living in poverty. The overwhelming majority of women in Canadian federal prisons are Aboriginal women. In Ontario, Black women are seven times more likely to be incarcerated as white women for similar offences (Council of Elizabeth Fry Societies of Ontario). Girls are more likely to be sent to prison for minor crimes, due to vulnerability and inequality. Homelessness and survival sex are often factors in young women's criminalization (Elizabeth Fry Society, 2007).

4.8.6 Trauma And Its Relationship With Anger And Violence

> *"Expressing anger and engaging in controlling behaviours are important to acknowledge as part of the range of responses that individuals might have to violence"* (Ristock 2002a).

The psychological, physiological, behavioural, and social impacts of trauma in the lives of women and girls are complex and are discussed elsewhere in this tool kit and by numerous other authors (see for example Herman 1992; Briere 1996; van der Kolk, McFarlane and Wiesaeth 1996; Ross 2000; and Haskell 2003). Our purpose here is to focus solely on those aspects of the disruptions to a survivor's capacity to modulate emotions (affect regulation), specifically anger and rage. Our hope is to create a context, and hopefully, make space for the understanding of the expression of anger and aggression by women who are both survivors and perpetrators of violence. Our intention is not in any way to discount or minimize the destructive nature of violence and aggression, nor to deny responsibility for one's violent behaviour(s).

We need to acknowledge and understand the contexts and motivations for a woman's use of violence, while at the same time holding her accountable for her actions.

Anger is a natural consequence of trauma, where physical, emotional, spiritual and/or sexual integrity is attacked or compromised. Experiences of childhood sexual abuse can result in chronic irritability, unexpected or uncontrollable feelings of anger, and difficulties with the expression of anger (Briere 1996). There is a tendency to either suppress feelings of anger or to misdirect the expression of anger. Either situation can be detrimental. Angry feelings that are suppressed can become internalized as self-hatred and depression, which in turn may be a motivating factor in the expression of self-harming behaviours. The external expression of anger and rage resulting from experiences of childhood abuse may "increase the likelihood of—but in no way guarantees—aggressive behaviour" (Briere 1996). Van der Kolk (1996) suggests that in trauma survivors, extreme feelings of anger and helplessness may be expressions of reliving the trauma.

As well, emotionally intense and overwhelming feelings of anger and rage may be dissociated. As Lori Haskell (2003) explains, "the emotional arousal at the time of the traumatic event is often so overwhelming that the woman may need to disconnect from her feelings to survive. The terror and disconnection she experiences is not coded as a typical memory, but rather as a series of disconnected emotions, visual perceptions and sensation." The result when these disconnected feelings of anger are triggered is a seemingly uncontrollable expression of rage that may manifest as emotional or physical aggression.

> Yvonne Johnson, writing in her journal in prison, reflected on how she had come to understand her motivations and actions:
> "...because of past abuse ... relapses into mental anguish and body memories channelled into mental confusion, which in effect cause physical reactions to the nervous system, where all physical, mental, spiritual [faculties] can't have up-front knowledge to recognize what in effect is happening. Where memories and emotions arise. Yet [my] mental and physical [faculties] couldn't co-exist then to recognize what was happening. But now I do. I see for the first time in my life, to understand. I am not crazy. I must ponder this idea more. ... I was defeated before I recognized it. But now I can put a name to it, to attempt to explain it now. It is not incurable. I can cure myself, since I have a reason that caused it. So if I deal with the reason, then I can work to make the problem go away. (Wiebe and Johnson 1998)

A key feature of a trauma survivor's experience is extreme emotional states that alternate between hyperarousal and numbing or shutting down emotionally when a threat is perceived (van der Kolk and McFarlane 1996). Emotions shift from being totally "on" or totally "off" with little capacity to modulate the intensity, or to interrupt the cyclical shifting from feeling overwhelmed to emotionally shut down. In essence, the nervous system becomes overactive, alternating between rage, panic, hypervigilance and, at the other extreme, depression, deadness, disconnection and exhaustion. The cycling can be rapid, or a person may experience times when they become stuck in one state or the other for extended periods of time.

Ordinarily, our nervous system serves to alert us to pay attention to potentially important situations. When we become chronically hyperaroused we lose that capacity and become easily triggered in response to minor stimuli as if we were experiencing a major threat; setting off intense feelings of panic, fear, anxiety and anger. Thus, we lose the capacity to rely on our own bodily sensations to warn us of potential danger. As well, our ability to accurately decipher the messages our nervous system is sending us and to articulate what we are feeling is greatly compromised. What we are left with is a narrowed range of emotion, where we overreact and may threaten others or shut down and freeze, and a tendency to go immediately from stimulus (fear) to response (fight or flight) without realizing what made us upset (van der Kolk and McFarlane 1996; Haskell 2003).

4.8.7 Relationship Between Substance Use/Withdrawal And Anger[1]

The relationship between anger and violence and substance use and withdrawal is not simple and often may be very individual. Substance use generally does not cause anger or violent behaviour, although the use of substances may increase aggressive reactions and lower one's inhibitions to acting on persistent feelings of anger. Alternatively, in some people, substance use may block the expression of anger and create a sort of 'numbing' effect. Amongst women in prison, the links between substance use and violence are significant and Steffensmeier (1995) suggested that women were more likely, than were men, to commit an offence while under the influence of alcohol or drugs. Even when a person stops using alcohol or drugs, the anger and the reasons behind the anger remain. Feelings of anger will not be processed unless they are dealt with directly.

The following discussion explores some specific ways that some substances affect feelings of anger and the potential for violence. Information is also included on the process of withdrawal and its effects on nervous system arousal and irritability.

Psychiatric medication (anti-depressants, anti-anxiety medications—including benzodiazepines—and anti-psychotic medications) are not typically associated with increased incidence of anger, unless the person has an adverse reaction to the drug, in which case this could cause irritability. But if withdrawal from any of these medications is abrupt, increased agitation, anger, and aggression are likely. In fact, aggravated anger and hostility has been found to be a common response to benzodiazepine withdrawal.

The most common over the counter drugs to be linked to increased anger and aggression are steroids. Yet there are reports of mild to moderate agitation as an adverse reaction to central nervous system stimulants, such as caffeine. Ephedrine, a stimulant frequently used as an appetite suppressant, is also associated with mild to moderate agitation. And even Tylenol, which is most frequently used for pain relief, is reported to be linked to increased irritability in some cases. In fact, many medications, including herbals, can produce unpleasant symptoms and behaviour changes when discontinued.

Crystal meth is the illicit drug most highly associated with increased anger and aggression during use and withdrawal. Cocaine and heroin produce strong irritability while coming down from the drug. Heroin and other opiates produce many uncomfortable symptoms during withdrawal, including agitation, but cocaine produces relatively mild withdrawal symptoms. Marijuana withdrawal symptoms can include irritability and anger.

Withdrawal from nicotine is also reported to cause anger, irritability, and aggression. Mild to severe agitation is associated with alcohol withdrawal.

Withdrawal Process, Anger And Violence

While in active addiction, there is artificial stimulation and disruption to normal brain activity, which impairs clear thinking and how emotions are expressed.

The process of withdrawal from substances starts with an acute, intense, and immediate withdrawal. Post-acute withdrawal symptoms generally appear seven to 14 days into abstinence, during the stabilization phase, and can last anywhere from six months to two years.

The severity of the post-acute withdrawal symptoms usually depends on two factors. The first is the amount and degree of brain dysfunction or disruption that has been caused by the length of use, and type of chemicals used, and any injuries that occurred associated with the use. The second is the severity of the psychological and social stressors that may occur in early recovery.

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1   Many thanks to Mireille LaClaire for her invaluable work on this section.

During the adjustment period, difficulty in thinking clearly, expressing emotions, memory, coordination, sleep disturbances and stress are all common. The physical and emotional symptoms of post-acute withdrawal occur in random cycles during recovery, and are often misdiagnosed as other disorders (manic depression is one of the most common).

It takes time for the brain to right itself as neurotransmitters return to normalcy and adapt to a life without mood altering chemicals.

4.8.8 Women's Use Of Violence

"The image of a victim as pure, innocent and helpless looms large in dominant culture, and makes it difficult to speak about agency, strength, and resiliency, and even a 'taste' for revenge as other features of being a victim" (Ristock 2003).

Women's use of violence is difficult for many feminist anti-violence workers to accept. We have discounted women's violence and clung to the myth that women aren't violent, focusing our attention on the real and devastating impact of men's violence towards girls and women. In our attempts to counter assertions of mutual abuse, we have minimized and glossed over women's desires to talk about their own use of violence.

"The simplistic notion that males are violent and females are not contains a grain of truth, but misses the complexity and texture of women's lives" (Simpson 1991). When feminists side step the issue of women's use of violence, there is no effective response to those who claim that women are just as violent as men, or to others who perpetuate the myth that women who use violence are extraordinary freaks. This lack of discussion denies women agency or choice in their lives and leaves society with little understanding of women's use of violence and how we should respond and help women heal.

4.8.9 Women's Use Of Violence In Intimate Relationships

Heterosexual Relationships
It is undeniable that some women use violence towards their male partners. In order to effectively address and intervene with women's use of violence we need to keep sight of the differing patterns, contexts, motivations, and consequences that usually occur in women's and men's use of violence (Worcester 2002).

In a recent article, Ellen Pence and Shamita Das Dasgupta (2006) advocate for the return to the use of the term "battering" as a way to move away from the trend to gender-neutralize violence in heterosexual relationships and distinguish among the five categories of violence that they identified in their research[2]:
1) battering as an ongoing pattern of intimidation, coercion, violence and other tactics used to establish and maintain power and control over an intimate partner
2) resistive or reactive violence
3) situational violence—where no pattern of abuse is present
4) pathological violence—violence stemming from the use of alcohol or drugs, mental health issues, physical disorders, and/or neurological damage. In these cases, when the pathology ends, so does the violence
5) "anti-social" violence, where violence is not restricted to a particular partner and gender and is more generalized

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2   Their conceptualization of violence in this manner is a result of 15 years of interviews with men and women arrested for domestic abuse and the review of hundreds of police and court documents in the United States.

Their intention in this delineation is to deepen our understanding of how violence is used by both men and women in relationships, and to develop interventions that address the specific form of violence used.

In recent years, there has been an abundance of studies that look at men's and women's use of violence in relationships. Many of these studies fail to consider the possibility that women and men experience and use violence for different reasons and under different circumstances (Das Dasgupta 2001). Pence and Das Dasgupta (2006) point out that while it is not uncommon for women to use violence in intimate relationships, "it is exceptional for her to achieve the kind of dominance over her male partner that characterizes battering." The overwhelming majority of women in their study used violence to resist their partner's violence, often in conjunction with drug and alcohol use. Other studies of women's use of violence in heterosexual relationships corroborate the low incidence of women as "primary aggressors" maintaining a regime of domination and terror over their male partners (Hamlett 1998; House n.d.; Swan and Snow 2006). Heterosexual women who have sought service through the Women Who Use Violence Project in Victoria, BC[3] were motivated to use violence for at least one of the following reasons:
a) in self-defense, as a way of protecting themselves and their children against their partner's abuse;
b) in retaliation, to pay back an abusive partner; and
c) to express feelings of frustration at being controlled or invalidated or as a way to be heard by their partner (Marleau, pers.com).

Lesbian, Bisexual, Transgender and Queer (LBTQ) Relationships

> *"Abuse is always inexcusable ... there are many different kinds of abusive relationships and many reasons for why it happens. ... we need to understand those differences so that we can respond in more helpful ways. The same responses are not appropriate for someone who has experienced abuse her whole life and occupied both the perpetrator and victim positions, someone else who has been terrorized by her first lesbian lover, someone else who uses violence to retaliate against an abusive partner, and someone else who has experienced shifting power dynamics where both she and her partner have been verbally and emotionally abusive. The violence still has to stop: in looking at these contexts, I am not saying that women are not responsible for abuse, but I do think we need different ways of responding that attend to the complexities of these differing power dynamics"* (Ristock 2002a).

Since the mid-1980s, advocates working on the issue of violence in same-sex relationships have challenged the myth that women are not violent and that women do not use violence in relationships (see Hart 1986; Renzetti 1992; Kaschak 2001; Ristock 2002a). The challenges of effectively responding to the issues of same-gender relationship violence are multi-faceted and deeply seated in women's experience of oppression and violence in a patriarchal and misogynist society, and the added intersection of homophobia and transphobia in a heterosexist and transphobic society. For instance, from the perspective of the anti-violence field:
a) acknowledging women's use of violence has been seen as detracting from the very real and devastating impact of men's violence against women;
b) acknowledging that women are violent challenges traditional notions of power and control and victim/perpetrator dichotomy;
c) Working with women and their use of violence poses difficulties in determining who is violent and who is not; and
d) Working with women who have perpetuated violence creates challenges in providing service in a safe and secure manner.

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3 The Women Who Use Violence Project is a community collaboration amongst various community and anti-violence agencies in Victoria, BC. The project, originally conceptualized by Alayne Hamilton and Jude Marleau, began in 1997/8.

From the perspective of the LBTQ community, addressing issues of violence in relationships feeds into:

a) the stigma of being marginalized
b) a fear of further marginalization by providing evidence that a LBQ sexual identity or a transgender identity is unhealthy; and
c) fear of experiencing homophobia and/or transphobia when seeking help.

While this is changing, these challenges still remain and feed ongoing discussions and debate within the anti-violence and LBTQ communities.

In what ways is my agency a safe place for LBTQ people to access services? In what ways is it not a safe place for LBTQ people? How do we make our services accessible to LBTQ people? What challenges would this pose for our agency? In what ways does/could our service think and work outside the gender binary system? What would it mean to our program to move beyond the dichotomy of victim or perpetrator and work from a "both/and" perspective?

While the issue of assessment of who is violent in same-gender relationships is complex and beyond the scope of this tool kit[4], it is, however, important to be aware of the context, intent and effect of women's use of violence in LBTQ relationships in order to accurately determine what service is required. In her book, *No More Secrets: Violence in Lesbian Relationships,* Janis Ristock (2002a) identified three basic styles of relationship dynamics:

1) A pattern where there is a distinct perpetrator and victim and that follows a predictable cyclical manner that intensifies over time;
2) Fluctuating power dynamics, where the violence is more relational in nature and there is no distinct perpetrator or victim and no clear pattern to the abuse; and
3) Fighting back in response to violence. In her study, the reasons for fighting back included fighting back as a way of coping, as a form of resistance, as an intentional act to cause harm and/or a self-defense reaction.

4.8.10 Women's Use Of Violence Towards Children

Women's use of physical violence towards children is something that has been difficult for us to acknowledge. Yet, just as women's use of violence in relationships needs to be recognized and discussed in the context of societal and interpersonal pressures, so does the use of violence towards children. Washburne (1983) suggests that women's abuse of children is a direct result of their own oppression in society and within the family. Women's motivations for abusing children can be complex, and often are related to their own experiences of abuse. Such factors as isolation, stress and lack of support, poverty, cultural beliefs and practices, and learned behaviour and parenting styles, have all been suggested as explanations for women's use of violence towards children.

Regardless of the reasons for women's use of violence towards children, our role as counsellors and support workers is to help women find ways of disciplining and relating to children in a non-violent manner, and dealing with their own anger and stress. We have a legal obligation to report child abuse, but we can engage with a woman to support her in reporting and getting help to make changes (see section Empowering Strategies When Children are at Risk).

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4   For a fuller discussion of assessment issues see: Hamlett (1998), Ristock (2002a, 2002b), and Northwest Network of Bisexual, Trans and Lesbian Survivors of Abuse (www.nwnetwork.org).

4.8.11 Strategies For Working With Women's Anger And Violence

The discussion below focuses on the use of violence in relationships. We acknowledge that women use anger and violence in other situations as well. Many of the strategies for intervention outlined in this section are by no means unique to violence in intimate relationships and can be effective in helping women deal with the expression of anger and the use of violence in other situations. Much of the literature that outlines strategies for dealing with women's use of violence specifically, rather than strategies intended for men and extrapolated to women, has been developed for women who use violence in relationships. As well, many anti-violence workers are faced with women who want to work on their use of violence in their relationships.

W hat comes up for me when I think of addressing issues of women's anger and/or use of violence? What supports would I need from my agency, supervisor, and colleagues in order to work with women on these issues?

Motivations For Women's Use Of Violence

Following from the above discussion, women's use of violence in intimate relationships (including heterosexual and LBTQ relationships)[5] can be separated roughly into four main categories:

Primary physical aggressors
Women who use tactics of power and control, including violent behaviour, to control their partners can be considered to be primary aggressors. According to Hamlett (1998), the number of women in her program that are considered primary aggressors is small and most are violent to a female partner. These women generally have histories of growing up in abusive households, witnessing the abuse of their mothers, and often experienced physical and/or sexual abuse themselves and have identified with the perpetrator. Often these women posess a sense of entitlement justifying their use of violence. Some women have histories of violent behavior in their teen years, and may have been abused in at least one adult relationship.

Relational or Situational violence
This is where violence is used to achieve goals, without any pattern of control or domination and where power fluctuates back and forth continuously in the relationship. The use of violence in this relationship is unusual and generally arises in highly stressful situations. Either partner may use violence, but they do not attempt to dominate each other in other ways.

Self-defence
The overwhelming majority of women who are violent are acting in self-defence. Often a woman is trying to get away from a violent incident or when she knows her partner is about to be abusive. This generally is the situation with women who are abusive to male partners. She may also be fighting back in retaliation to physical, emotional and psychological abuse. This is common in abusive lesbian relationships.

"Never-again" mode
Some women, regardless of the gender of their partner, move into a survival mode of thinking, "no one is ever going to hurt me that way again," and use violence as a way of protecting themselves. These women, almost without exception, have experienced violence in at least one adult relationship, and often have histories of childhood abuse.

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5   Based on and adapted from materials in Hamlett (1998), Pence and Das Dasgupta (2006) and Ristock (2002a).

Notes to Table 1

(Please refer to Table 1 on next page)

Understanding what motivates a woman to use violence is essential in developing an intervention that fits for her and has the opportunity for a positive outcome. Table 1 suggests possible interventions that may be most effective with women whose violence arises out of the differing motivations, as outlined above. It is important to recognize that there may be some overlap between these categories, and the interventions need to be congruent with an individual woman's specific circumstances. Presented here is a broad framework for addressing each grouping, as well as suggestions of specific skills and information that might prove helpful. These are not exhaustive. There are many issues that can be addressed, but we have tried to put forward those points that are most pertinent. The categories are not necessarily mutually exclusive; for example, a woman who is abused in one relationship and takes a stance of "never-again" in a subsequent relationship runs the risk of becoming the primary aggressor in that relationship, although that is not a given.

Table 1. Main Categories of Women's Use of Violence in Relationships and Possible Interventions[6].

WOMEN'S USE OF VIOLENCE	DEFINITION	POSSIBLE INTERVENTIONS	SPECIFIC SKILLS AND KNOWLEDGE TO ENHANCE	OTHER CONSIDERATIONS
PRIMARY AGGRESSOR	An ongoing pattern of intimidation, coercion and violence to establish and maintain dominance over an intimate partner. A primary aggressor often feels a sense of entitlement that justifies her violence.	• change beliefs • needs to take responsibility for her behaviour • learn to stop violent behaviour • focus on keeping partner safe • learn to establish a more equitable power base • provide external monitoring	• safety and containment • affect management skills • plan for avoiding violence • recognize and manage triggers and cues • understanding abuse and its impact on others/self • identify irrational beliefs, negative self talk, self-control • respectful expression of anger • communication skills	Programming needs to be similar to the type of programming for abusive men, but designed specifically for women and incorporate a framework of intersectionality (Ristock 2005).1
RELATIONAL VIOLENCE	Relational between partners and is used to achieve goals without any pattern of power and control, intimidation, and domination.	• create behavioural options • resolve issues resulting in conflict • provide counselling	• all strategies listed above • for primary aggressor • strategies for resolving conflict • counselling to resolve any past trauma	A thorough assessment of the dynamics in the relationship is important to distinguish this from the primary aggressor.
SELF–DEFENCE	Violence used in defending one-self from another's violence. The violence may be used in retaliation, as a coping strategy, as a form of resistance.	• develop ways to get and stay safe • provide information about violence in relationships	• safety planning • safety and containment • affect management skills • understanding abuse and its impact • respectful expression of anger	Often this form of violence ends when the abuse stops.
"NEVER-AGAIN" MODE	This is a form of survival thinking where abuse is used to protect oneself from being abused. This may occur within a relationship where abuse has been present but has stopped or when entering a new relationship.	• develop ways to stop her violence • learn to assess her own safety level • ensure partner's safety from abuse • provide counselling	• safety planning • all strategies listed above for primary aggressor • strategies for resolving conflict • counselling to resolve past abuse	This woman may have difficulty interpreting her partner's behaviour or in distinguishing "early warning signs of abuse."

6   This table is compiled from information from multiple sources, including Hamlett (1998), Pence and Das Dasgupta (2006), and Ristock (2002a), Jude Marleau (pers com), and the author's own experience in working in the Women Who Use Violence Program.

The following are some questions that may be helpful in assessing a woman's use of violence and in making decisions on what interventions would be most useful. These can be used in conjunction with other assessment tools or questions in determining an overall plan of action or as general questions to guide you in engaging with a woman around her use of violence.[7]

It is important to keep in mind that the behaviour itself is not the point. Virtually any behaviour can be used by a person to survive violence or to establish power and control over another. What is crucial in assessing dynamics of abuse in relationships is a) the context in which the behaviour occurs; b) the intent of its use; and c) the effect of the behaviour.

Relationship Violence
- How long have you been in this relationship?
- Have you ever been separated?
- Are you together now?
- When did the violence or abuse begin in your relationship?
- How often has it happened? (Length of cycle?)
- Is there a pattern of issues or circumstances that lead up to the violence or abuse?
- When do you use violence? In what circumstances?
- When was the most recent incident of violence or abuse? Describe what happened.
- What led up to this violent incident?
- What motivated you to use violence in this instance?
- How do you understand your use of violence?
- What were you hoping would be the outcome of your use of violence?
- What effect did your use of violence have on your partner?
- What impact did your use of violence have on you?
- Has the violence or abuse increased in intensity or frequency?
- Describe your most violent incident against your current partner.
- What injuries has your partner had? Has your partner ever required medical treatment?
- Has your partner ever needed medical treatment but not received it?
- What injuries have you had?
- Do you and your partner have disagreements about sex? What kind of disagreements?
- Do the disagreements get resolved? If so, how?
- Do you pressure your partner to be sexual when she/he does not want to be?
- Does your partner pressure you?
- In general, how do you handle disagreements in your relationship?
- In general, what do you think your reasons are for using violence?

Violence In Other Relationships
- As an adult have you been physically violent to:
  - Parents or in-laws
  - Siblings
  - Friends
  - Children
  - Strangers
- Were you ever abused in past relationships?
- Were you ever abusive towards another partner?
- Describe your most violent incident toward your past partner.

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7   These questions form part of the assessment used in the Women Who Use Violence Project, developed initially by Jude Marleau and revised by Cathy Welch.

SECTION 4   SPECIALIZED KNOWLEDGE

Impact On Children
- Have you or your partner ever received help or intervention because of abuse toward the children?
- Has the Ministry of Children and Family Development ever been involved? If yes, how so?

Childhood
- Did either of your parents/caregivers have a problem with alcohol or drugs or a mental health issue?
- Did either of your parents/caregivers use violence or abuse towards the other?
- What was it like growing up in your family?

Criminal Justice System Involvement
- Have the police ever been called to your house because of an incident of violence between you and your partner?
- Have you ever been charged with spousal assault?
- What was the outcome?
- What is the status of any current charges?
- Are there any current protective orders in place?
- Has your partner ever been charged with spousal assault?
- What was the outcome?
- Are there any current charges?

Strategies For Addressing Angry Or Violent Behaviour
The following discussion looks at some specific exercises and information that can be used with women to help them to become aware of their behaviour, what fuels that behaviour and to develop skills and strategies for change. These are examples of the kinds of tools that anti-violence workers, whether Community-Based Victim Service Workers, Outreach Workers or STV Counsellors, can use to assist clients. . In some sub-sections are hand-outs that can be photocopied and given out as "homework" or discussed in session. These handouts were originally developed for a woman who use violence group[8] and thus can be used in both an individual and group format. The materials were originally designed for women who are violent to a female partner because LBTQ people in our society so often have to "translate" material to make it relevant. Gender neutral language is typically used and in some cases a variety of situations are presented; thus these materials can be used with any woman regardless of sexual orientation or affectional preference. Working to end violence in any relationship is part of the bigger goal of working to end violence and oppression in the broader culture.

> How have I learned to address and work through my feelings of anger? How have I learned to transform them into positive action?
> What skills have I learned that might be helpful to another woman?

Creating Alternatives To Anger And Violence
Women who are seeking to find alternatives to their inappropriate expression of anger and/or use of violence and who are working towards a vision of life without violence need to:
- develop an understanding of what abuse is
- understand the factors that contribute to abuse and violence
- gain insight into their behaviour
- develop a variety of tools that they can use to begin to shift their behaviour.

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8   Adapted from materials developed by Hamlett, N. 1998. Women Who Abuse in Intimate Relationships. Domestic Abuse Project, Minneapolis, MN.

We know that the main factors that contribute to the decision to use violence, no matter what the motivation, include:

- Violence as a learned behaviour. Violence and abuse are learned from such sources as family of origin, past experiences of violence, and socialization. While women are not socialized to be in control or be aggressive in the same way that men are in our culture, women may learn that violence is a normal response of powerful people or that violence is a way of gaining power. We may also learn that violence is a way to solve problems, resolve conflicts, and express or cover up strong feelings. As well, using violence without experiencing any negative consequences can be a powerful reinforcement for future violence. Our role in assisting a woman to make changes in her life can be to help her understand where and how she learned that violence was an appropriate way of behaving, while at the same time holding her responsible for her violent behaviour.

- Opportunity to be abusive or use violence. There are numerous cultural messages that support violence as an acceptable way of meeting one's needs. As well, experiences of oppression and violations by institutions and systems, and isolation, all contribute to providing fertile ground in which violence can occur. It may be useful to engage in a discussion of the societal, institutional and personal opportunities that contribute to her use of violence.

- Stress. The ways in which stress can contribute to the use of violence and abuse include: a restricted ability to recognize one's feelings, difficulty in the ability to express one's feelings and/or needs, an association of anger and violence as being linked (i.e. can't be angry without being violent), the association of violence with power (the only way to be powerful—or not submissive—is to be violent), and the use of violence to reduce stress. Helping women to understand emotions and stress and developing a variety of ways to manage stress levels can be useful.

- Choice. In every situation there is a point at which the individual makes the decision to use violence/ abuse. Sometimes the person imagines the situation before it occurs and mentally rehearses what she will do. At other times the person is unaware of the point at which she makes the choice. Regardless of why a person choses violence, it is still a behaviour of choice that has its costs and its benefits or payoffs. In her decision to move towards non-violence it is helpful for her to consider what the negative consequences of her behaviour are as well as what she gets out of being abusive. The payoffs for abusive behaviour are usually short-term and temporary. In contrast, the costs are often long-term and permanent (loss of relationship, loss of intimacy in the relationship, limited or no visitation with children, etc.).

Violent and abusive behaviour is learned and is a choice for which alternatives can also be learned. Women need to learn to choose non-violent behaviour to solve problems, get needs met, deal with strong emotions, etc. The strategies that follow can be used as one aspect of a woman's journey to living without violence. In addition, information on such issues as emotions other than anger, violence in relationships and the progression of violence, effects of violence on children, boundaries, assertiveness, non-violent communication skills, etc. are an intricate part of her healing. We have not included handouts and discussions of these topics, as there is a wealth of information and materials from a broad range of sources that are readily available. The strategies presented here are examples of one way of thinking about and leaning about how to move towards non-violence that have been developed specifically to address women's anger and use of violence in relationships. They are only one component of her overall journey.

Handout: Costs And Payoffs For Abusive Behaviour

It's up to you to decide whether the payoffs are worth the costs for abusive behaviour. Payoffs are usually immediate, but they do not last very long. The costs, however, tend to last longer. They usually set in immediately after the abuse, but sometimes are delayed.

Payoffs are based on valid needs. For example, everyone wants to have a sense of their own personal power; everyone wants a sense of control over their life. Abusive behaviour is an unacceptable way to get one's needs met or to get payoffs. Having power and control over yourself is a much deeper and longer lasting sense of power.

Full acceptance of responsibility for your abusive actions includes accepting the costs and payoffs. As unpleasant as the costs are, when you accept the consequences of your violence, you are beginning to take responsibility for it.

Payoffs
- Physical "rush"
- Satisfaction
- Feel better: calm and relaxed; relief from stress, tension, anger, and rage
- Using my power to control my partner
- Getting what I deserve
- Escape from: shame, fear, hurt, sadness, institutionalized homophobia or heterosexism
- Get my way
- Get in the last word
- Make my partner do what I want and listen to me
- Give myself permission to be violent again
- I get a "quick fix"

Costs
- Shame, low self-esteem, embarrassment
- Lack of satisfaction; loss of self-respect
- More stress, tension, anger, and rage
- Ruined relationship; loss of intimacy and trust
- Legal: arrest, criminal record, jail, fees, time and energy, probation
- Keeping secrets from our friends
- Hurt my partner: loss of partner's special qualities; partner becomes angry, resentful, withdraws affection or gives only out of fear; partner leaves relationship
- Hurt my children: fear, disgust, school and behaviour problems, suicide, kids learn to use violence, lack of safety and security, loss of self-esteem
- Repeated loss of relationships over the years
- I spend years repairing the damage

Identifying Cues

The first step in developing strategies for changing angry or violent behaviour is to begin to identify the cues that precede abusive behaviour. Often anger and violence is explosive, seemingly coming out of the blue, and women feel that it was totally out of their control. Some may say that they could feel it coming but couldn't stop it. Others are much more aware of their feelings but still feel powerless to stop it. And still others use their anger and aggression quite deliberately. Below are two sheets that can be given to women to begin their work of identifying the signs of increasing stress:

1) Cues: What are they?
2) Cues worksheet

In preparing a woman to do this exercise, reassure her that this is hard work and encourage her to take care of herself in doing it. It may be helpful to walk her through the explanation of what cues are. Once she has completed her worksheet, it is important to engage her in a debriefing conversation about the experience of doing the exercise and what she learned about herself. Encourage her to see the process of escalation that leads to her choice of abuse/violence. Abuse doesn't "just happen." Help her to identify very specific cues of escalation; the more specific the cues, the more useful the information is for changing her pattern.

Responses to this exercise vary. Some women seem to intuitively understand the process, are ready to do the work, and have a good sense of self-awareness. For other women it is harder. For instance: some women may be more random thinkers and struggle with the process of getting very concrete and specific. It is often helpful to have this client describe one or more incidents, and while she does to make notes on the worksheet, and then walk her through the process of how you got from her story to identifying the cues. This may be enough to get her started. Encourage her to continue the process on her own. Still other women may have difficulty with this process because it produces feelings of anxiety or shame. In any case it is helpful to talk about how difficult this work is. In engaging in this work we are asking women to look at the very behaviours they may want to forget and push out of sight.

Anger is an emotion that warns us that something is wrong. It can be that we are being hurt or threatened, that our rights are being violated, that our needs are not adequately being met, or that we are giving too much

(Lerner 1997).

Handout: Cues–What Are They?

One of the first steps in shifting your expression of anger and violence is to identify the cues, or warning signs that you are in danger of acting abusively. They are warnings or signals given *before* an incident of violence or abuse. Your cues are part of the build-up or escalation phase in the progression of violence.

Your body and mind sends you signals to let you know that your stress levels are building. It is your responsibility to watch for your cues and to take yourself away from the situation before you become violent or abusive. Cues tell you that you are under stress. It is especially important to watch for cues that you have identified as having happened before several of your past abusive incidents.

Cues can be divided into seven different types. Within each type the level of stress can be rated as: low (1-3) on a scale of 9, where 9 is the highest), medium (4-6) and high (7-9).

1) Physical changes. This is the way your body registers stress and includes a variety of physical sensations that you feel as your stress builds. Some examples include: sweating, tension in jaw and neck, stomach in knots.
2) Emotions. These are the feelings that you feel during escalation and can include: frustration, anger, powerlessness, hurt, confusion, embarrassment, hatred, impatience, rage.
3) Self-talk. These are messages, often negative, that go through your brain (not out loud). These can include thoughts and plans to be abusive. Self-talk can be about yourself, your partner or the situation. Examples include: I hate this crap, I'll show you not to mess with me, I can't ever do anything right.
4) Red-flag words. Words that you say out loud or hear before you act out. There are two kinds of red-flag words: your partner's and your own.
   a) My partner's red-flag words. These are words you hear your partner say before you become violent. For instance, if you escalate when your partner asks you to do the dishes, then the request is a red flag. The point is not to blame your partner, but to identify what is said that gets you to escalate your behaviour.
   b) My red-flag words. What you hear yourself say that indicates you are escalating your behaviour. These words often come out before abuse and can include such statements as: "Don't bug me," "Leave me alone." This does not include abusive words like: "bitch," "fuck you," etc. These are part of the abuse.
5) Behaviors or actions. Things you do when stressed and/or escalating. Examples include: Ignoring partner, isolating, interrupting.
6) Mental images. Things you imagine or rehearse in your mind during your build-up. Some people say that before the explosion they picture in their minds being violent or abusive. Some other examples include: imagining your partner watching TV all day while you were working, imagining your partner saying negative things about you to friends or family.
7) Situations. Events, incidents and circumstances when you get angry or increase your controlling behaviours. Situational cues are somewhat different than other types of cues. Situations can happen at any time, and aren't necessarily tied to a particular level of escalation. For example, if you are cut off in traffic and your level of escalation is already high, then you will respond differently than if you were at a low level. They can include occurrences or scenarios that precede abusive behaviour or that contribute to your feeling of escalation and/or increased controlling behaviours. Some common situations include:
   a) arguments, b) bad days at work, c) disagreements, d) holidays, e) major decisions, f) money stress

Handout: **Cues Worksheet**

TYPES OF CUES	LOW LEVEL 1–3	MEDIUM LEVEL 4–6	HIGH LEVEL 7–9
PHYSICAL CHANGES			
EMOTIONS			
SELF–TALK			
RED–FLAG WORDS (My partner's)			
RED–FLAG WORDS (My own)			
BEHAVIOURS/ ACTIONS			
MENTAL IMAGES (I IMAGINE …)			
SITUATIONS			

Developing A Plan For Avoiding Violence

There are three components that go into creating a plan of action towards avoiding violence. They include:

1) a plan for preventing and managing stress
2) a plan for how to manage crisis situations
3) a self-control action plan

We can work with a woman to help her identify what each of these components can consist of for her.

The first part of the plan explores stress management techniques and strategies. There are many things that go into reducing and preventing stress. Stress management, generally, involves regular physical exercise to help relieve pent-up stress, activities that help relax and nurture, relaxation techniques, and other things that promote wellbeing. A minimum of 20 minutes of exercise three times a week is recommended. Some examples of things that promote relaxation and that are nurturing are: taking a bath by candle light, reading, playing musical instruments or listening to music. Relaxation techniques include activities that directly relax the body and mind, and can include breathing exercises, meditation, yoga, mindfulness exercises and massage. Other things that can work to reduce stress may include spiritual practice, nutrition, identifying and altering commitments when over-extended, and paying attention to time-management.

The second part of the plan for avoiding violence is the crisis plan. This consists of identifying strategies for learning non-abusive ways to handle a crisis. In this exercise we are beginning to help the woman develop skills of containment of abusive behaviour, and developing strategies for not only keeping her partner safe but also herself. The crisis plan should include an articulation of how and when she will take herself away from escalating emotions, a plan for communicating that to her partner, how she will use her time-out time in constructive ways, and a plan for returning to her partner or the situation. As well, the crisis plan will identify supports she can use if she needs to, and reminders of positive things (not related to the situation) she can do for herself to calm herself down; for example, grounding techniques or containment.

The third aspect is the development of a self-control plan. This involves integrating the information about cues, stress management and crisis planning into a comprehensive articulation of the levels of escalation and a corresponding plan for de-escalation. It shows how at the lower levels there are many options for interrupting the escalation process, whereas at higher levels the options become more limited. The self-control plan thus becomes not only a tool for responding to crisis, but also a means to avoid crisis.

It may be helpful to work with the woman on refining and including things in her plan that are realistic, do-able, and focused on herself, not on her partner. This may take some time to work through and is a living document that she can add to as she develops more skills and confidence.

Developing An Understanding Of The Relationship Between Core Beliefs, Behaviour And Affect

Situations, circumstances, self-talk and negative beliefs may be different for women who are controlling their partners through violence and abuse and women who are responding to a partner's control, abuse or threats by being violent themselves.

Women who are using violence and abuse as a means to control their partner, and who feel entitled to be in charge, will need to look at changing some of these basic beliefs about relationships. They will need to challenge the belief that they are entitled to get what they want, and that threats and violence are justified. They need to address core differences between a relationship based on shared power and equality and one based on power and control.

Women who are responding to partners who use abusive means to control them need to learn that *they* are only in charge of *their* behaviour, that violence is not an acceptable way to respond to violence and abuse. They need to look at how their negative core beliefs keep them feeling powerless. They must begin to be proactive in taking charge of their life in ways that are respectful to both their partner and themselves.

Often, the difference between "self-talk" and "beliefs" is difficult for women to distinguish. It is not so important that they can make clear distinctions, but that they articulate the beliefs which are often unconscious assumptions they hold about life. For instance, an example of *self-talk* could be "She is late," or "She should have called to tell me," or "He is probably out having fun, forgetting all about me." Examples of *beliefs* would be: "If she really loved me she would know I'm sitting here feeling bad," "If she loves me she will make sure I don't feel bad," "If he has fun without me, he will probably leave me," "I'm not worth loving."

Changing shame-based or other negative core beliefs relating to abuse is fundamental to becoming non-abusive. Even if one is acting in self-defense or in situations where one's partner is not being respectful, and may in fact be controlling or abusive, it is possible to impact the outcome for oneself through changing negative core beliefs and self-defeating internal messages.

Communication Skills

Learning how to communicate in ways that are respectful and nonviolent is for many women a skill to be developed. Their experience often has been seeped in violence, abuse and disrespectful ways of addressing another person. Skills that teach clear, healthy communication are another important piece of moving beyond anger, aggression and violence. There are many styles of communication and these may also vary among cultures. What may be viewed as respectful in one culture may be rude or inappropriate in another.

Specific models of communication are not included in this section as they are numerous, and many of us already work with clients in developing these skills. Information about healthy communication is readily available in books and manuals and through the Internet. Some of the key components of healthy communication include assertiveness training, use of "I" statements, strategies for effective listening, strategies for working through conflict and many other techniques and strategies.

It is important when teaching assertiveness skills to remind women that these are not simply new ways to harass one's partner, but a way to communicate what one wants. It is all too easy for those who believe they are entitled to get what they want to use this tool as another means to insist their partner do what they feel they want. It may be that negotiation and compromise will be necessary to resolve any differences. On the other hand, women who are using violence against a controlling partner need to know that being assertive rather than aggressive will not stop their partner's controlling behavior.

Whatever her situation, learning these skills can help a woman to be clear and respectful in her communication. It does not guarantee she will get what she wants, or change her partner's pattern of behavior. There may be a change in her partner. A person who has been controlled or abused may eventually, over time, learn to trust consistent assertive behaviour by an abusive woman who has stopped being violent or abusive. Such behavior may have little impact on an abusive male partner. Quite the opposite may occur. He may somehow use this new behavior to criticize and demean her further. The change for her comes in a sense of her own inner strength and power.

Discuss where silence fits into communication. Silence may be a very important piece of information about the communication patterns between people. In an abusive relationship, silence on the part of one's partner may indicate fear. Because of episodes of abuse, the partner who has been victimized may assume that if she talks to her partner, she will be abused. On the other hand, many people who are abusive control their partners

by being silent. Silence can be a control mechanism that keeps the partner anxious and uncertain about a situation. Silence can also feel punishing, abusive, and withholding.

Another consideration in discussing communication is to pay attention to non-verbal communication. A great deal of information can be transmitted via non-verbal cues. Four non-verbal cues that can be of importance in abusive relationships include:

Context: In abusive relationships, the context has a significant impact on the "shared meaning" between partners. For example, in a relationship in which no abuse took place, the question, "What did you do today?" might seem innocent. However, the same question asked by a person who has been abusive might signify a totally different understanding. Perhaps on previous occasions the question was followed by interrogation and accusations. Physical or sexual abuse may have followed. Therefore, because of the context established by abuse, the "innocent" question might provoke fear and tension in the partner being abused.

Proximity: Physical distance in abusive relationships may be used as a tool to intimidate or threaten. If a person who is abusive approaches her partner and gets within inches of his or her body and/or face, this may be a way for the abuser to exert control and to intimidate the victim.

Body language: Gestures, facial expressions, or body posture may convey threatening or intimidating messages. Clenching fists, raising a hand, scowling, or narrowing the eyes may be ways in which an abusive person uses body language to send messages of intimidation, threat and control.

Use of voice: The tone, volume and inflections of voice can have a great deal to do with the content and intent of the verbal message. Sarcasm, rage, and belittling can be conveyed with these elements.

In rebuilding trust and intimacy in a relationship after stopping the abusive behavior, the person who is abusive needs to be congruent—that is, she needs to match her words and subsequent actions. For example, saying "I love you," and then hitting the partner is incongruent. Abuse sends an incongruent message because people who abuse usebehaviors that are usually reserved for people they hate with people they supposedly love and care about. Incongruent or incomplete communication puts the burden of understanding on the receiver.

In order to change the context established by abusive behavior, the person being abusive needs to be congruent and consistent. As the saying goes, "actions speak louder than words." If a person who has been abusive says to her partner, "I want to listen to what you have to say and I would like you to be honest," she has to be congruent and hear what the partner has to say without being abusive.

An assertive belief system values people's basic human rights. An assertive belief system holds that all people deserve respect. Further, discussion about assertive belief systems may clarify ways in which clients can take care of and respect themselves. Consider the question: "What is intimacy?" Open communication and active listening contribute to intimacy. Intimacy is about expression of emotion and feeling, allowing one to be vulnerable, and treating one another respectfully. Sex and physical touch are not essential parts of intimacy. Obstacles to intimacy include: fear of abandonment, fear of exposure and loss of control.

Often women who are trying to stop being abusive feel that their only option is to withdraw or become passive, to say nothing rather than to become violent. Teaching communication skills is a way to help them take a step further, to state clearly their need or desire. Being able to do this often helps women to not escalate when in the past they would escalate. This takes a great deal of practice over months. It is important that women get ongoing support as they change these behaviors, and that they not expect praise from their partners who are dealing with their own process.

Conclusion

Women's use of anger and violence is often intricately related to their lived experience of childhood abuse and violence, adult victimization, and marginalization and oppression in a patriarchal society where sexism, classism, racism, homophobia and heterosexism, transphobia, and experiences of colonization abound. Our role as anti-violence workers is to engage with a woman in not only the ways that she is victimized by other's violence but also in the ways she uses her anger and aggression towards others. Her healing is dependent on examining all of who she is, including those aspects of self that are "not so pretty." Whether she uses her anger and violence to defend herself from abuse, to keep herself safe from being abused "yet again," or to control a situation or a person, we can help her find ways to learn new skills and to develop strategies that are based in respect and nonviolence.

The specific strategies to address and help women find alternatives to angry and violent behaviour include a wide range of supportive and therapeutic techniques; some that speak directly to the behaviour and others that work to resolve past trauma. In this section we have outlined some specific strategies that may help women to become more aware of their behaviour, its impact on self and others, and some tools for developing new skills that we believe will be useful to both Community-Based Victim Service and Stopping the Violence workers alike.

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4.9 Empowering Strategies When Children Are at Risk

By Kashmir Besla

4.9.1 Addressing Child Protection Issues With Women

An anti-violence worker and client relationship is based on trust and confidentiality, and it is most effective when these two conditions are honoured. However, there are times when a worker is unable to keep information in confidence because she has a duty to report. This section focuses on working with mothers in a situation where child protection concerns arise and must be reported to the Ministry for Children and Family Development (MCFD).

Workers are bound by law and ethics to keep information between themselves and their client confidential. The important exceptions to this are:
- If a worker's notes are ordered by the court
- If a child is in danger and in need of protection
- If a client has indicated that she will harm herself
- If a client has expressed a plan to harm others

At the onset of contact with a woman, a worker should inform her of the limits to confidentiality and the situations that arise which necessitate reporting. Although a worker has a duty to report, she can often do this without damaging her relationship with the client. The worker can remind the woman about her strengths as a parent, she can empower her with knowledge about MCFD, and she can be an advocate for the woman. With the client's consent, she can tell the social worker about the circumstances in which the woman is living:
- Is there a concern for the client's safety because of an abusive partner?
- Are there issues of mental health or substance use?
- Would the family be at greater risk of violence because of MCFD involvement?

If the woman is living in an abusive relationship, it may be beneficial to remind the social worker about *Best Practice Approaches: Child Protection and Violence Against Women* (MCFD 2004), which guides investigation and interventions for children's safety when a mother's safety is compromised by violence. The document is available on the BCASVACP's website www.endingviolence.org.

The worker can assist the client through the reporting process and still maintain a trusting relationship. In order to do this, the worker needs to keep the client informed as to what will happen once MCFD is involved in her life. Each step of the process should be explained to the client before MCFD gets involved. Many social workers are aware of the client's needs and are able to keep them informed about their file. The client has the right to know what decisions are being made for their family. The relationship will be enhanced if the client feels that the anti-violence worker and social worker are working collaboratively with her and not against her. The client should feel that she has a voice in the decisions that are being made, and this will allow her to better follow through on programs or supports that may be available to her. The client may feel that she is being judged by MCFD and that her ability to parent is in question. Creating a safe place for her fears to

be expressed will mean a great deal for her. The worker can help the client to deal with any circumstances that may arise as a result of MCFD involvement. A child apprehension is a traumatic and emotionally difficult time for parents. Having the anti-violence worker as a support and confidante can be very empowering for the client.

Workers can keep notes regarding their work with the mother. The notes should be brief and written in an objective manner, so that the content, if subpoenaed, is not misinterpreted. The notes should be written with a respectful and client-centred approach. For more information on note keeping and documentation when child protection issues exist, please see *Records Management Guidelines: Protecting Privacy for Survivors of Violence*, published by the BCASVACP and BC/Yukon Society of Transition Houses (2006; available at www.endingviolence.org).

Case #1

During a counselling session in your office, a woman says, "I was so angry with my seven-year-old son Johnny for speaking to me in such a rude tone; I slapped him across the face. Something happened to me then and I began to hit him over and over and it wasn't until he fell down the stairs that I realized what I was doing and stopped. I felt remorseful immediately. I tried to console him but he was very upset. I noticed marks on his face and I began to panic. I knew what I had done was wrong, and I could not take it back. He went to school this morning, and I'm afraid that he will tell someone. I didn't tell him not to tell, even though I wanted to. I feel like a terrible parent; it's just been so difficult being on my own."

Once a disclosure of abuse has been made, the counsellor should ask the client if she remembers a conversation about the limits to confidentiality, which they had discussed in their first session. This reminds the client that although most of what she has shared with the counsellor is confidential, there are times when the counsellor must report the information she has received.

The counsellor can offer to be with the client when she calls the Ministry to tell them what has happened. The call can be made from the counsellor's office or the client can call from her home. The counsellor should check with the client to ensure that the call has been made. She can say, "I will call you at four this afternoon, and if you have not made the call, then you know that I will have to do it for you." This allows the client to make a decision as to how the incident will be reported and by whom. If this is done in a respectful and caring manner, the relationship between the counsellor and client may not be harmed. This will also allow the counsellor to work with the client as she deals with the Ministry, and to continue to provide support around any circumstances that arise from this situation.

The worker can also ask the woman about any concerns she may have about dealing with MCFD. What fears or challenges is she thinking about? The woman may have grown up as a child in ministry care, or she may have wished that someone had intervened in her parents' life when she was growing up. It is important to be curious and pose questions that will assist the woman to understand why she is feeling a particular way, and to help her to work through her feelings.

Without minimizing the abuse towards the child, the worker should be mindful of the circumstances that can lead to such events. The client may have a history of harming her children, she may have other young children in the home that may be at risk, or she may have lost guardianship of other children to the Ministry because of her inability to parent. Or she may have a multitude of issues that are compromising her ability to parent. She may never hit the child again and would like to learn about why she got so angry and what she should have done instead. She may want to attend a parenting program to be a better parent and improve her skills or access other support services.

We can work with the woman to gain greater understanding of what is happening in her life and what she needs to be the mother she wishes to be, but the incident of abuse must be reported.

Case #2

An anti-violence worker is supporting a woman who has recently left an abusive relationship. She is dealing with the trauma of years of physical and emotional abuse by her husband. The woman has three children aged eight, six and two. She discloses that she has been consuming alcohol on a daily basis to try to cope with the stress of raising the children and trying to keep her job. The use of alcohol has increased and the woman is experiencing black outs. In a recent incident, her eight-year-old son told her that she forgot to turn the stove off after preparing some noodles for dinner. The empty pot was left on the burner causing it to smoke. Luckily the son saw it and was able to remove it from the stove and place it in the sink. He opened the windows and turned on the hood fan to clear the smoke. The mother had fallen asleep, tired from working, picking up the children from daycare, preparing dinner and drinking more each night. She reluctantly shares this incident with the worker, adding that she must have just fallen asleep because she was tired. The worker is concerned that the client is using alcohol to cope with her stress and is placing her young children at risk.

The information that the woman has provided is enough to decide that the children may be at risk. This incident must also be reported. Again, the intention is not to punish the woman, but to allow the Ministry to investigate all of the factors and make a determination. They may be able to assist her with services that will help her to cope, as well as address her misuse of alcohol. Had the eight-year-old child not noticed the scorching pot on the burner, the outcome of this incident could have been tragic. The woman may be sharing this information with the worker because she recognizes that she is not being the responsible parent that she would like to be. The report may lead to a positive outcome.

In some situations, the risk may not be as easy to determine, but the worker should not second-guess herself about reporting. She should allow the social worker to conduct their investigation and make the appropriate recommendations. If a worker is struggling about determining whether the information she has received warrants reporting, she could consult with a supervisor in her agency or with an intake worker at MCFD without disclosing identifying information.

4.9.2 Relevant Definitions Within Child Protection

The protection of children is considered one of society's greatest obligations[1]

In addition to the normal rules of criminal and civil law that apply to everyone, there's also specific provincial legislation called the Child, Family and Community Service Act, which is intended to protect children from sexual and physical abuse and neglect. The Act defines a child as any person under 19.

How Are Abuse And The Neglect Of Children Defined?
The law defines these things as follows:
- "Sexual abuse" means any sexual touching or intercourse between a child and an older person, or using a child for sexual purposes.
- "Physical abuse" means any physical force or action by a parent or adult which could injure a child and which exceeds "reasonable discipline."
- "Neglect" means failing to look after the physical, emotional or medical needs of a child, so that the child's health, development or safety is endangered.

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1   This information is copied entirely from the Government of British Columbia website http://www.gov.bc.ca/mcf/.

You Must Report Suspected Child Abuse Or Neglect

If you have reason to believe that a child has been or is likely to be abused or neglected or is in need of protection, section 14 of the Child, Family and Community Service Act requires you to report your suspicions to the Ministry of Children and Family Development. It doesn't matter if the suspected abuser is your neighbour, patient, family member, church member or other person. Your duty to report your suspicions takes legal priority over any claim of confidentiality or privilege. It's an offence not to report suspicions of abuse or neglect. The only exception is for a lawyer who may suspect his or her client.

What Will Happen Once A Report Has Been Made?

Once a report has been made to MCFD, a social worker will go to the home or school to meet with the child and the family. The child protection social worker will:

- determine if the child needs protection;
- contact the police if a criminal investigation is required;
- coordinate a response with other agencies, if necessary.

If a child is in immediate danger, police should be called to intervene and a child protection social worker should be contacted to determine whether the child is in need of protection.

4.9.3 Fears Surrounding MCFD Involvement

As you have read, child protection is a serious matter in our community, and the duty to report should not be taken lightly. Just as many service providers do not know very much about the role of child protection agencies, most members of the public also do not know very much about MCFD. The Ministry has done a poor job in educating the public about its mandate in the community. Most people believe that all they do is take children away from parents that hurt them. The Ministry can provide resources and help parents to be better parents. They do not wish to remove children unless the child is in danger from the adults who are supposed to be taking care of them. A fear that many parents have is that their child could be taken away from them, and this can be a devastating experience for both parents and children. Most people know that the Ministry has strong legal representation, and they may not know their own legal rights.

Women also have justifiable reasons to feel scared and untrusting of MCFD. They have heard of situations in which children were removed from their homes for long periods of time, and relationships were affected. They do not want to be involved with MCFD if it is going to be a long and emotionally painful experience. The intervention of MCFD can also put women at greater risk from abusive partners, who may blame them for the MCFD involvement. As a result of MCFD investigation and concern, women may feel depressed, or use substances to minimize fear and sadness. Many further issues may surface as a result of the Ministry involvement and it is understandable that many women feel like they are losing control of their lives or at least their parenting when MCFD is contacted. It is important to continue to work with a woman in the process of reporting, investigation and intervention to encourage her own advocacy, to focus her on her strengths and to inform her of her rights.

4.9.4 Collaboration As A Means Of Supporting A Woman's Rights

The relationship between the Ministry and the client does not have to be adversarial. The two parties can work together to provide the best plan for the child, because the safety and protection of the child, along with his/her mother, is paramount. The social worker is often concerned about the entire family.

If the worker can help the client to have a better understanding of the Ministry and help her to work with them, the process will not feel as daunting or isolating. Women who have no support from friends, family or

service providers find the task of going through the process of court dates and hearings very stressful. If a child has been removed from the home, there are ways in which parents can work with the Ministry to have the child returned to them. Again, this would be an important time for the worker to support the woman.

Fostering healthy working relationships between the anti-violence worker and the Ministry is useful in being a strong advocate for the client. The social worker does not want to be perceived as the enemy and the anti-violence worker does not want to be seen as being against the importance of the work that the social worker is doing. Having strong working relationships with the social worker will allow her to have access to decisions and interventions, which in turn benefits the client. It also shows the social worker that the mother and worker are discussing the needs of the family and are actively working to keep the children safe. For more information on establishing a collaborative relationship see the sub-section Advocating for a woman's access to mental health services, in the Treatment Issues with Mental Health and Substance Use Problems section.

The relationship between the client and worker does not have to end because there are child protection issues to address. This can be a very helpful time for the counsellor to work with many different aspects of the client's life. The key to maintaining and strengthening this relationship with the client is:
- to be honest about everything that is going on
- to help her understand the role of MCFD
- to empower her in her rights and responsibilities as a parent
- to encourage her to work with the Ministry rather than against them

Most parents try to do the best they can. Some make decisions that they later learn are not right, and they regret their choices. Others struggle with their ability to parent, and are prepared to face the consequences and learn from their mistakes. Regardless of the parent and their experience, the involvement with the Ministry can be made more manageable if the worker can work with them in whatever ways are most helpful. This may include:
- not judging the client for her mistakes
- seeing the mother as the expert on her own life
- finding resources like parenting classes
- providing emotional support while she goes through this process

At the end of the day, the safety of the child as well as the mother is the most important concern, but being able to assist a woman as she tries to be a better parent to that child can be equally as important.[1]

(Endnotes)
1 The information provided is based on my 14 years of working with families, women and children. I do not consider myself an expert in the mental health or child protection fields. My writing is based on the invaluable experiences that I have had working with people, and it is from those experiences that I share with the reader my ideas. I am also influenced by my own lived experience of being a female, a woman of colour and a mother.

5.1 Historical Perspectives on Violence Against Women in BC

By Sarah Leavitt

5.1.1 Introduction

Organized responses to violence against women began in Canada and BC in the 1960s with feminist activism. At that time, the common point of view about violence against women, both in society and in the legal system, was that it was a private matter, that it was a normal and acceptable way for men to treat women, that women were to blame for being assaulted, or even that most or all claims of violence were untrue.

Public understanding of violence against women has increased and policies and legislation have, in many cases, improved. However, violence against women continues to be a widespread and serious problem. Attitudes and beliefs that condone or ignore violence, as well as social conditions such as poverty and lack of resources, contribute to the continuation of violence.

Throughout the 70s, 80s and 90s, sexual assault centres, women's centres, transition houses, counselling programs and victim services programs were developed in BC to respond to violence against women. Most of these programs drew on feminist research and writing as they developed their understanding of violence against women and their approaches to counselling and advocacy. Anti-violence programs have also drawn on anti-oppression theory, a wide range of counselling approaches, popular education techniques and other sources as they have developed. For example, Judith Herman made significant developments in the approach to trauma work, shifting the focus from breaking the silence and telling our stories to staged trauma counselling work.

In many programs, workers have moved from a peer counselling approach to a more standardized or professionalized way of working. This has helped programs gain credibility with government and other sectors, although there have also been suggestions that this has taken away from the grassroots nature of feminist intervention and analysis. However, despite increased professionalization, the feminist values of empowerment through listening, understanding and following a woman's needs remain the core of the programs. Workers and trainers in the anti-violence field are engaged in an ongoing process of integrating clinical skills with feminist approaches.

As society and government have become more educated about violence against women, important improvements have been made to policy and legislation. However, in recent years there have been significant cuts to many anti-violence programs, as well as to income assistance, housing and other essential parts of the social safety net. Anti-violence workers are finding that the women they work with face more serious and complex challenges to surviving, including extreme poverty, lack of housing, mental health issues and substance use issues.

Throughout the last few decades, innovations have been made in counselling and advocacy techniques, training and support for workers, resource development and public education. Training programs have been developed that specifically address the intersections of violence, mental health and substance use. Anti-violence workers are increasingly aware of the ways in which substance use and mental health issues affect a large number of survivors of violence.

Anti-violence organizations have made concerted efforts to build and participate in cross-sector coordination initiatives in order to improve relationships with other sectors such as police, Crown, health, addictions and multicultural and Aboriginal agencies. Efforts have been made to make services accessible to all women, including women who are oppressed by racism, homophobia, poverty, ageism and ableism. Services have also been developed that serve specific communities, such as Aboriginal people, lesbians, older women and immigrant women. Despite the enormous challenges facing the anti-violence sector, services and approaches to violence continue to develop and women's organizations remain one of the primary resources for women facing violence.

5.1.2 Some Key Dates In The History Of Anti-Violence Work In Bc

Taken from *Significant Events in the Development of Effective Responses to Victims of Crime and Violence Against Women, Children, Seniors and People with Disabilities in BC, Canada and Internationally,* by Linda Light (2000); *Events Impacting Community Coordination on Violence Against Women,* by Community Coordination for Women's Safety (2002); and *Victims of Crime Victim Service Worker Handbook,* by the Justice Institute of BC and MPSSG (in press 2007).

1965	*Criminal Code of Canada* is amended so that women do not have to prove a greater level of injury if they are assaulted by a partner than if they are assaulted by a stranger.
1972	The first sexual assault centres and transition houses are established in BC. The BC government passes the *Criminal Injuries Compensation Act,* allowing victims of crime who have suffered personal injury to apply to the Workers' Compensation Board for compensation.
1973	The first victim assistance programs are organized by police departments in various Canadian cities. BC's *Child and Family Services Act* is implemented to protect children from physical and sexual abuse.
1974	The first police-based victim services begin operating in BC.
1976	The United Way of the Lower Mainland sponsors the Symposium on Family Violence, and the first treatment program is set up for men who batter.
1978	BC/Yukon Society of Transition Houses is founded.
1980	The Canadian Advisory Council on the Status of Women publishes *Wife Battering in Canada: the Vicious Circle*, by Linda McLeod, and Vancouver Women's Research Centre and Vancouver Transition House publish *Battered and Blamed: A Report on Wife Assault from the Perspective of Battered Women.*
Early to mid 1980s	A strong network of victim support programs grows out of grassroots activity to provide justice-related support to victims of crime

1982

MPs laugh when MP Margaret Mitchell (NDP, Vancouver East) raises the issue of battered women in the House of Commons.

Wife Battering: A Report on Violence in the Family is submitted to Parliament.

The Solicitor General of Canada directs RCMP to pursue charges in cases of relationship violence where there are reasonable and probable grounds.

RCMP develops national charging policy.

1983

Criminal Code of Canada offence of rape is changed to sexual assault to parallel physical assault provisions, emphasise the violent nature of the crime, delete the requirement for corroboration in sexual offences and make it a crime for a man to sexually assault his wife.

Peter Jaffe and Carole Ann Burris publish the results of a study: *Wife Abuse as a Crime: The Impact of Police Laying Charges.*

1984

The Solicitor General of Canada provides funding to select police agencies across Canada for police-based victim assistance programs, including Vancouver and New Westminster.

The BC Ministry of Attorney General Wife Assault Policy is implemented, the first of a series of BC policies guiding justice system responses to violence against women and children.

1985

National Women's Legal Education and Action Fund (LEAF) is established.

1986

The BC Ministry of Attorney General's study of its policy recommends "increased use of arrest, police/Crown counsel/ Corrections networking, efforts to address reluctant witnesses through Victim Support Workers, RCMP/municipal police joint training, municipal police record-keeping to parallel that of RCMP, and Crown record-keeping to compare statistics on RCC's (reports to Crown Counsel) recommending charges and charges approved." Revisions are made to the policy based on these recommendations.

1987

The BC Victim Assistance Program is established, incorporating existing programs. Police-based programs are increased and community-based programs are funded to serve women and children victims of violence. The first Crown-based program is established.

1989

The BC Wife Assault Coordination Program is established, providing funding to six communities to set up local coordinating committees. This is in addition to Victoria, where the coordinating committee is already funded.

1990

Three Aboriginal victim assistance programs are established in BC.

The budget for the Secretary of State Women's Program (which provided funding to many grass roots feminist organizations including shelters) is reduced from 12.7 million to 9.2 million.

1991

The first community-based victim support program for multicultural victims of crime is established.

1992   Family Violence Research Centres is established.

The BC Association of Specialized Victim Assistance and Counselling Programs is established.

BC Women's Programs launch the first media campaign and public information pamphlet against violence against women.

Is Anyone Listening?, the report of the BC Task Force on Family Violence, is published.

1992   Ten million dollars of funding is approved for the new Stopping the Violence initiative, including funding for 80 new counselling programs for women, increased funding for community-based victim assistance in the form of funding for new Sexual Assault/Woman Assault programs and the first province-wide program for children who witness abuse.

An *Act to Amend the Criminal Code* (sexual assault) restores protections for sexual assault complainants by restricting questioning on sexual activity (rape shield), defines consent and restricts the defence of "honest belief" in consent.

Criminal Code of Canada is amended to include criminal harassment.

BC's *Wife Assault Policy* is revised and updated as the *Violence Against Women in Relationships Policy.*

1993   The "K file" designation is introduced to help track and monitor vawir cases.

BC Ministry of Attorney General establishes Victim Services Division (now Victim Services and Crime Prevention Division of the Ministry of Public Safety and Solicitor General).

BC's *Victims of Crime Act* is amended to include stalking and threats.

The Protection Order Registry is introduced, including certain types of civil and criminal orders. Access restricted to police.

1995   *Criminal Code* amendments are proclaimed that make peace bonds easier to obtain and more effective and increase maximum penalties for breaches.

The *Criminal Injury Compensation Act* is updated to include criminal harassment, uttering threats, criminal injuries at work and support for immediate families of deceased victims.

The BC Provincial Health Officer's report identified freedom from violence as necessary for the health of British Columbians.

1996

In Vernon, BC, Marc Chahal murders eight members of his ex-wife Rajwar Gakhal's family and kills himself. Justice Josiah Wood heads an inquest into the killings that results in recommendations for better response by the police and justice system to violence against women.

An Act to Amend the Criminal Code (sentencing) is proclaimed, including requiring the court to consider a victim impact statement and providing that abuse of a spouse or child, or abuse of a position of trust, shall be considered an aggravating factor in sentencing.

Crown Victim Witness services are doubled.

BC's *VAWIR Policy* is amended to include criminal harassment.

The first Domestic Violence Unit is established, in the Vancouver Police Department, with counsellors and police officers working together on high-risk domestic violence cases.

1997

An Act to Amend the Criminal Code (production of records in sexual offence proceedings) is proclaimed, restricting the production to the accused of irrelevant personal records.

The Federal Family Violence Initiative reduces its funding from $136 million in 1991 to $30.7 million.

2001

The Community Coordination for Women's Safety Program is started by a partnership between the BCASVACP and Victim Services Division.

2002

The *Crime Victim Assistance Act* comes into effect in BC, replacing the *Criminal Injury Compensation Act.*

BC's Crown Victim/Witness Services are eliminated and funding is cut to sexual assault programs and women's centres, along with numerous other cuts and changes to legislation affecting violence against women in BC.

2005

Bill C-2 introduces *Criminal Code* amendments expanding testimonial aids and protection for vulnerable witnesses.

5.2 History and Contribution of the Mental Health and Addiction Sectors

By Tessa Parkes

Introduction

"In British Columbia, addictions, mental health and primary care services were for many years delivered as separate systems under different ministries, with little opportunity for coordination. ... Even when both disorders have been identified, treatment is difficult, since traditionally, the two systems have differed in philosophy and approach" (Richter 2004).

In this section of the tool kit we discuss the major historical and philosophical developments in each sector, the key ideas and priorities that are most current, and what services are currently comprised of. We also discuss the most significant and relevant contributions of each, acknowledging that the two sectors have historically operated separately and in isolation of each other.

5.2.1 Mental Health Services: Historical And Philosophical Developments

"People with mental illness, their families, and the mental health professionals who try to support them are currently in a state of dynamic tension. At no other time in history have there been in place the knowledge and understanding, the range of techniques, and the human resources to create the kind of revolutionary change in the lives of consumers that is now possible. New therapies, the emergence of evidence-based programs, a new awareness of population health factors, and consumer and family empowerment all contribute to this powerful mixture. The source of tension is clear. It can be found in the gap between what we know we can do and what we are actually doing. We can intervene early in psychotic illness and dramatically improve its course, but in most cases we do not. We can house people effectively in ways that support independence and dignity, but in many cases we do not. We can support people in regular work and school settings, but in most cases we do not. We know that consumers can help each other if they have the resources, but in most cases they do not. The list could be longer" (Trainor et al 2004).

History And Philosophical Developments: The Big Ideas

Mental health services were described as the "orphan child" of health care in Canada by the Romanow Commission's Final Report on the Future of Health Care in Canada (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). Many commentators have expressed concern about mental health and addictions being marginalized in health care, despite the huge social and economic implications,

and the fact that these problems are so widespread in Canadian society. There have been profound changes in the mental health system over the past 30 to 40 years; indeed, it has been described as being in a permanent state of reform (Arboleda-Florez 2005).

In most countries, the practice for many centuries was to send people viewed as "crazy" to asylums or mental hospitals that were located well away from urban centres.

Isolating people with mental health problems in rural asylums was known as the "custodial" model, and was based on an understanding of mental health problems/mental illness/madness as being incurable and the people afflicted as out of control, frightening and depraved. Over time, driven by new ways of viewing people with mental health problems, a desire to cut hospital costs, and new medications, this model gave way to the "deinstitutionalization" model.

Deinstitutionalization started in the 1950s and rapidly took hold in the 1970s, 1980s and 1990s, with the closure of long-stay hospitals and the discharge of patients into the community. Concepts such as empowerment, client/patient rights and citizenship began to be applied to this very marginalized and excluded group of people. These changes were undertaken as a health policy priority, but adequate planning and much-needed resources did not follow the hospital closures into the community: *"Beds were closed and psychiatric patients were effectively dumped on the streets with very little access to the needed supports"* (www.mooddisorderscanada. ca/social/senate/index.htm). While the sentiments and intentions behind deinstitutionalization were largely progressive, the result for many ex-patients was (and still is) homelessness, unemployment, poverty and victimization. Stigma and discrimination continue to make it very difficult for ex-patients to have a normal, valued community life.

> Policy and practice in the mental health field has been in a state of change and flux for the last 50 years. New ideas about the causes and "treatability" of mental health problems/mental illness, alongside changes in the ways that people who experience these problems are viewed, have radically altered the landscape.

Although the "service paradigm" and medical model still predominate in most public mental health settings, there has been a steady progress over the past decade, at least, towards including and involving consumers and their families in the design and delivery of services. Consumers themselves have been developing and communicating their own ways of thinking and understanding their mental health for many years (see Church and Reville 1988; Church 1996). Consumer emphasized the importance of a number of factors for quality of life, including:
- financial security
- decent housing
- meaningful work or vocational and educational achievement
- effective, sensitive and supportive services,
- response by services to the specific needs of women and other minority groups
- having friends and intimate relationships
- the elimination of stigma and discrimination

In practice many women have limited access to mental health care services.

> ❚❚Women consumers/survivors, where their voices have specifically been heard, are particularly concerned with needing mental health services that help them to deal with the following issues: victimization; parenting and child related issues; reproductive health, relationships and sexuality; menopause and aging; discrimination, rejection and isolation; loss and grief. They are adamant about the need for better access to non-medical interventions and a non-medical approach to their distress and life circumstances" (Cook, Jonikas and Bamberger 2002).

5.2.2 A Gendered Critique Of Mainstream Mental Health Policy And Service Provision

As a rule, mental health services have been very poor at taking gender into account in the understanding and treatment of mental health problems. A gendered approach to mental health and the mental illness/psychiatric system has been variously influential over the past 30 or more years, despite the hard work and advocacy of the women's health movement in Canada. Authors such as Phyllis Chesler (*Women and Madness*, 1974), Barbara Ehrenreich and Deirdre English (*For Her Own Good: 150 Years of Experts' Advice to Women,* 1978), Susan Penfold and Gillian Walker (*Women and the Psychiatric Paradox*, 1983), and Jane Ussher (*Women's Madness: Misogyny or Mental Illness*? 1992), amongst others, have made significant contributions in drawing attention to the ways in which gender and gender inequity intersect with mental health. These feminist critiques emphasize the ways in which women have been pathologized and over-medicated, over-diagnosed and underserved by psychiatry since its beginnings. For example, the diagnostic categories used in psychiatry have been described as distorting or obscuring women's lived experiences rather than being aids to effective treatment (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

In 1987, a Canadian Mental Health Association (CMHA) report, *Women and Mental Health in Canada: Strategies for Change,* detailed a range of key mental health concerns facing women and emphasized some of the main causes, such as the feminization of poverty and violence against women, outlining 25 recommendations for improvement. A BC-produced publication, *Hearing Women's Voices* (Morrow and Chappell 1999), added to the debate by arguing that women's mental health could not be understood in isolation from the social conditions of women's lives. Other more conservative mental health/illness associations have now also joined the call for change by stressing the importance of understanding the social dimensions of women's mental heath. For example, in 1996 the World Federation for Mental Health stated that women's mental health could only be understood by considering the biological, social, cultural, economic and personal contexts of their lives (Stewart et al 2006). A range of publications from around the globe now testify to gendered differences in prevalence of, pathways to and expressions of mental distress and mental health problems, clearly pointing to the need for gender-specific planning and programming.

Contributions and critiques based on gender have, like those on race and culture and mental health/illness, been largely marginalized and discounted within mainstream psychiatry. This continues to the present day with the 2006 Kirby Report, the federal report on mental health, mental illness and addiction in Canada, remaining gender-blind in its analysis (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). Despite the well articulated calls for a women-centred approach to policy, program and treatment. There is little evidence of this being translated into practice.

Instead, most mental health services for women continue to take an overly medical perspective, influenced by mental health research that is biased toward men and research and policy that inadequately addresses

women's issues (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). The majority of mental health professionals lack specific training or knowledge about women's mental health or women's issues in general. Very few staff feel confident and competent in dealing with women's experiences of violence, abuse and oppression. Professional education and training still largely ignores or marginalizes the now extensive knowledge gathered on gender and gender inequality and the associated impacts on women's mental health.

Given that the mental health consequences of violence and childhood sexual abuse are so extensive, including posttraumatic stress disorder, anxiety, depression, panic disorders, self-inflicted harm, suicide, eating problems/disorders, substance use, dissociative disorders and psychotic breakdown, it remains incredible that addressing these issues is still not prioritized in professional agendas.

In practice many women have limited access to mental health care services and have to contend with many barriers such as shortages of services/personnel, a lack of appropriate services for their needs, location or budget, and long waiting lists for more appropriate/community based services. Many women simply do not know where or how to access help for their emotional or mental health needs. Women with concurrent substance use problems, and who are Aboriginal, homeless, poor or in violent relationships, encounter even greater barriers in accessing services. Women who live in rural or Northern communities often need to travel long distances in order to receive help (http://www.mentalhealthconsumer.net/index-links.html). Women's responsibilities as mothers pose an additional barrier. Mothers (particularly those who are on welfare, who are single or who are in unsafe relationships) fear that they will lose custody or care of their children if they access mental health services (a realistic fear).

While there have been many advances in knowledge and theory, the medical model of understanding mental health problems remains dominant, especially within the formal public mental health system. Mental health services are situated within a psychiatric frame of diagnosis and medical treatment:

> "The psychiatric profession remains closely tied to day-to-day care through the
> need for formal psychiatric evaluation to establish diagnosis, and the prescription
> of medication for symptom management" (Centre for Addiction and Mental Health
> 2002).

Many interest groups are calling for radical change within mental health services, particularly for those groups least well served by the medical and psychiatric approach, including women (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

5.2.3 Main Contribution Of The Mental Health Sector

Taking a broader perspective on the mental health sector, one of its main contributions to the wider social welfare/support field has been the development of a strong survivor voice, which brings a new emphasis to issues of human rights, equality, empowerment, social justice and non-oppressive systems of treatment, support and care. While this critique is not having nearly as much impact as it could have, largely due to the continued strength of the dominant medical paradigm, the strong professionalization of the sector and the continued negative societal attitudes towards those with mental health problems, it is nonetheless a significant force for change.

A growing interest in trauma-informed care is another significant contribution being made by the mental health sector: acknowledging and responding to the links between child and adult experiences of violence and trauma and consequent mental health problems. How these developments change the mental health field over the next decade is hard to predict, but for women consumers/survivors it is clear that much change still needs to take place before the system becomes sensitive and responsive to their particular needs.

5.2.4 Current Configurations Of Mental Health Service Delivery

With a few exceptions[1], the funding, planning, delivery and evaluation of mental health services in Canada falls within the provincial mandate for health services. Hospital, community programs and physician services for mental health conditions are all publicly funded. Private counselling is not covered by most health care insurance plans. In Canada there is a close relationship between the mental health system and the criminal justice system. This is partly historical and partly due to the number of people, mostly men, with concurrent mental health and substance use problems.

The target population given most priority within current policy and practice are people diagnosed with severe mental illness (SMI) as opposed to individuals with mild or moderate problems. The term "severe mental illness" is used to designate those individuals with conditions that are particularly disabling, and is usually a result of the type of disorder (needs to be in the DSM-IV) and the level of functional impairment. "Functional impairment" means that the disorder substantially interferes with vocational capacity, creates serious interpersonal difficulties or is associated with a suicide plan or attempt at some time during the past 12 months. The DSM-IV defines as "severe" cases in which "many symptoms in excess of those required to make the diagnosis or several symptoms that are particularly severe are present, or the symptoms result in marked impairment in social or occupational functioning."

Certain diagnoses in and of themselves are considered to meet the criteria for serious mental illness without the level of functional impairment being considered. The ones usually included are:
- All cases of schizophrenia (a psychotic disorder)
- Severe cases of major depression and bipolar disorder (mood disorders)
- Severe cases of panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder (anxiety disorders)
- Severe cases of attention deficit/hyperactivity disorder (typically, a childhood disorder)
- Severe cases of anorexia nervosa (an eating disorder)

The rationale is that these disorders are so severe that they almost always lead to serious impairment if not treated. When advocating for a woman's access to mental health treatment, an advocate should outline how a woman's mental health concern is impacting her functionality (for more information, please see the sections Treatment Issues with Mental Health and Substance Use Problems, and Safety Planning for Women with Mental Health Issues).

In terms of the configuration of services, formal mental health services currently consist of various hospital, community agency and private practice based options. They are staffed by a range of professionals and para-professionals such as physicians, nurses, social workers, psychologists and occupational therapists, and have extended to providing services such as housing and vocational support as well as treatment. Family physicians, working alone, in groups or in conjunction with specialists, now provide the largest proportion of primary mental health care in Canada. There is an increased interest in providing shared care between family physicians and psychiatrists in order to enhance the capacity of primary care services to effectively address the mental health needs of their local populations (Centre for Addiction and Mental Health 2002).

1   Aboriginal people and other "status" populations have access to some federally funded programs.

Informal care (financial, social, emotional and practical) by families and friends also substantially contributes to the support received by those with mental health needs, despite almost no financial or practical supports. Again, a gendered perspective on informal care is important because of the high numbers of caregivers who are women. Caregivers significantly contribute to the care and welfare of others, with little support for their own needs and often to the detriment of their emotional/mental and physical wellbeing. Care in the community, the default policy position during and after deinstitutionalization, largely means people caring for themselves or being supported or cared for by female family members (Fast and Keating 2001). This is largely invisible in mental health policy and practice.

Key elements of services may include: case management, crisis response, housing, clubhouses, vocational/ educational/ employment support and consumer-run organisations and support groups/phone-lines. Assertive Community Treatment (ACT) teams are a fairly recent addition and are targeted primarily at people with severe mental illness coming out of psychiatric institutions into the community. Approaches to achieving a wide range of community services differ in rural and northern areas of Canada and BC, where a scarcity of resources and small populations dictate multiple professional and program roles (Centre for Addiction and Mental Health 2002). The range of community resources differs hugely from region to region and across urban and rural areas in BC.

For more information on specific treatments for mental health problems, please see Interventions for Mental Health and Substance Use Problems.

5.2.5 Substance Use/Addiction Services: Major Changes In Key Ideas And Ownership

> *"There are many passionate viewpoints as to the causal factors of addiction, how it can be prevented, the adequacy of resources, where the resources should be allocated and who should or should not manage the service delivery system. It is a subject area where almost everyone has experienced some impact in their lives and where everyone has an opinion. It is because of this that alcohol and drug services will always encounter tensions or a 'push-pull' in its service delivery focus and its organizational structure"* (Duffell 2004).

Alcohol and drug services have undergone enormous organizational and service delivery changes since their inception in the 1950s. At that time, treatment was mostly based on the self-help model associated with Alcoholics Anonymous (AA), and informed by an increasingly influential "disease model" of addiction that took over from the predominant "moral model" (Duffel 2004). The medical or disease model viewed addiction as caused by genetic and biological factors rather than weak or bad character, with the individual no longer personally responsible since the addiction was beyond their control. By defining addiction as a disease, a strong argument could then be made that individuals with these problems were deserving of treatment instead of criminals deserving punishment (BC Ministry of Health 2004). However, the disease of addiction was viewed as incurable and progressive, with any further use of the substance regarded as a relapse, whether or not it resulted in harmful consequences.

In the early 1970s in BC, alcohol and drug services were subsumed under a single Commission that took responsibility for all addiction services to the general population. However, the focus of this work was the criminal impact of addiction on society, rather than a focus on individuals with problems. It was during this period that the infamous methadone program and compulsory treatment of heroin users under the Heroin Treatment Act was instigated, allowing for the detention of users in BC's heroin treatment centre (Duffell 2004).

This unsuccessful approach was eventually discontinued and the Act repealed in 1982. Government then broadened the focus towards health, relocating addiction services under the Ministry of Health Alcohol and Drug Programs (ADP). Many changes occurred through the 1980s and 1990s, when policy documents pointed to the need for an increased focus on addiction services, better coordination of services and policy, and additional funds for prevention. Significant focus was brought to women's treatment in this period; women's day treatment programs were piloted and evaluated across the province and specialized women's residential treatment beds were consolidated at the Aurora Centre at BC Women's Hospital.

Since 2002, addictions service provincial policy has been located in the Ministry of Health Services and Health Planning and integrated with mental health into a Mental Health and Addictions Division. Policy direction for prevention is placed under the Population Health Division. With health care regionalization the five health authorities across BC are now responsible for alcohol and drug prevention and treatment program delivery, and an integrated system across mental health and addiction services is now emerging. In terms of women-centred care, merging mental health and addictions may turn out to be a good thing if the merger acquires a perspective that reflects the complexities of women's lives, the multiple contributors to mental illness or addiction, and the interactivity of treatment approaches (Greaves 2006).

5.2.6 Approaches To Treatment

Although there has been ongoing professionalization of the addictions field since the 1960s and 1970s, medical and psychiatric professionals now play a much less dominant role in assessment and treatment than psychologists, social workers and certified substance abuse counsellors.

Generally there is more emphasis on prevention and early identification in substance use/addiction settings than in the mental health sector.

Within substance use/addiction treatment and intervention settings there has been a tendency towards a one-size-fits-all approach to intervention; characterised by complete abstinence goals and a top-down, mandated, provider-set agenda. New approaches that avoid prescriptive and confrontational approaches and acknowledge a person's readiness and motivation for change (Miller and Rollnick 2002) are increasingly being utilized. These approaches are based on behavioural and social cognitive theories that suggest that addictive behaviour has multiple determinants and that individuals differ in risk depending on their own unique history. They have led to the development of more client-centred or user-friendly interventions that meet people where they are at, working alongside them in determining what they want to change in their behaviour and what their goals and priorities for change will be. Even the BC Ministry of Health has stated, "By placing the choice in the hands of the individual, there is acknowledgement that most addictive behaviours represent a problem in self-management that can be resolved by the individual" (2004). These client-centred approaches have the potential to improve the response to women with substance use problems; however, the emphasis on self-management does not address women's need for connection or needs for childcare or respite from mothering during treatment.

A major distinction in formal substance use/addiction services is between services/programs that take an abstinence approach to intervention and services/programs that take a harm reduction approach. The abstinence approach programs encourage complete abstinence from alcohol and other psychoactive drugs, and tend to be informed by the disease model of substance abuse and addiction. Programs that have moved towards using the social learning models of alcohol and drug use described above have harm reduction goals. Harm reduction is a public health philosophy/approach that gives highest priority to the reduction of potential harm from substance use and supports policies and practices that address risky behaviours without

requiring abstinence. Harm reduction goals include reducing the use of alcohol and drugs to lower the risk of severe consequences such as HIV and Hepatitis C infection from needle sharing, informing people about health consequences of their behaviour, and creating improvements in other areas of people's lives (please see section called Moving Towards Safety: Using a Harm Reduction Framework for more information).

Some addictions service providers are now grounded in a broad bio-psycho-social perspective (others widen this further to include spiritual aspects). This broad framework takes into account the ways that various dimensions of life contribute to substance use and are affected by substance use (www.heretohelp.bc.ca).

Although there has been a general move away from the moral model of addiction and substance use within the treatment system, people with addictions continue to be stigmatised within society as being of low moral character and weak-willed. Largely because of this stigma, most individuals with alcohol or drug problems do not go for help, support or treatment due to a reluctance to disclose use (Centre for Addiction and Mental Health 2002). Feelings of self-blame, shame and guilt are especially common among women

5.2.7 A Gendered Critique Of Mainstream Substance Use/Addictions Policy And Service Provision

Similarly to mental health services, substance use services have been very poor at taking gender into account in understanding causes and developing treatments. Prior to the 1970s there was virtually no research on women with substance use problems and almost no gender specific treatment programming. Since then there has been a steady increase in both the quality and quantity of research on women's substance use and a growth in specialized women's programming (Poole 1997). However, women continue to be underserved in both prevention and treatment programs and information about women's needs remains scarce in many areas.

There are still very few programs that are accessible and appropriate for women, especially for mothers, pregnant women, Aboriginal women, women with disabilities, lesbians, women offenders and women with co-occurring mental health or trauma issues. Many rural, northern and Aboriginal women, for example, need to leave their communities to receive care and treatment. In terms of access to treatment services there are many barriers for women, including lack of knowledge about services, and fears of confidentiality breaches, child apprehension, coercive treatment and blame or judgement. It is widely agreed that there is an urgent need for woman-specific prevention, harm reduction and treatment approaches (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

Some examples of comprehensive woman-centred care have recently begun to emerge and these ideas are now successfully guiding some community-based and acute care policy and programming for women with substance use problems (see Poole 2003; Burgelhaus and Stokl 2005). The last few decades have seen the development of specialized day treatment programming for women, for example, which takes a holistic health approach and addresses barriers to access such as child minding and transportation costs (Day/Evening/Weekend Programming for Women or DEWW). The Aurora Centre at BC Women's Hospital is another example of woman-centred care, a provincial treatment setting that provides residential and day treatment, and support for early intervention with women to prevent FASD and other alcohol and drug related developmental disabilities. Fir Square is an 11-bed unit comprehensive prenatal and postpartum program that meets the needs of women with problematic substance use. Through liaison activities with community groups, and using a harm reduction approach, the program provides consolidated support for pregnant women, including addictions support. Evaluations of these woman-centred programs, and others like them, indicate substantial benefits for women that use them, ranging from increased engagement in treatment to a wide range of health improvements for women and their children (Poole 2000).

> **G**ender, race and culture, age and other social determinants need to be better researched, prioritised and taken into account when designing and delivering substance use services, so that gender and culturally sensitive services are the norm rather than the rare exception.

5.2.8 Main Contribution Of The Substance Use/Addictions Sector

The main contribution of the substance use sector, in BC at least, is a change in paradigm from abstinence focused, confrontational interventions to client-centred, harm reduction approaches. While this is not present everywhere, and can still be very vulnerable to policy changes, it is a driving force for change; indeed, BC has a reputation for being a world leader in harm reduction in relation to drug treatment. The strong history and presence of the self-help sector is also a contribution of this sector.

There is also an emerging holistic model in the substance use field that has the potential to build on the merits of motivational, educational and cognitive-behavioural approaches, evidence-based pharmacotherapy, public health informed harm reduction, by adding other holistic/integrative techniques such as acupuncture, meditation and stress management (BC Ministry of Health 2004).

5.2.9 Current Configurations Of Substance Use/Addictions Service Delivery

Like mental health services, most addictions services are now funded by provincial governments and delivered through regional health authorities for the population at large, and by the federal government for on-reserve Aboriginal people, members of the armed forces and those in the federal corrections system. Also, again with similarities to mental health, services are not only provided by specialized programs but also delivered in hospitals (chemical dependency resource teams) or through outpatient or home-based arrangements.

> **R**ecent reform of substance use/addiction services has placed a high priority on early identification and intervention and on the development of a wide range of community-based services that sit along a continuum of care that includes withdrawal management, comprehensive assessment, brief intervention, more intensive outpatient or day treatment, short or longer term residential treatment and continuing care.

A "stepped care" approach has been developed that staggers support, care and treatment depending on the client's needs, usually starting with the least intrusive level of care and then stepping up or stepping down, depending on the results from ongoing outcome monitoring. Those who are referred to specialized services have more serious problems. Counselling is provided in many arenas, such as schools, workplaces, community-based social services and corrections agencies as well as the more traditional substance use treatment services. Family physicians may also provide counselling and prescribe drugs to treat drug and alcohol problems, especially in rural areas where there may be few specialized alternatives (Centre for Addiction and Mental Health 2002). Women and their advocates have complained of the shortage of family physicians and services for women across BC, particularly outside the urban areas.

In general, treatment provided by specialised services tends to be non-medical in approach and referrals are made to outside medical and psychiatric services if needed. Self-help groups continue to play an important role in local treatment systems; indeed, far more people attend these groups than seek help from specialized treatment programs (Centre for Addiction and Mental Health 2002). These groups are self-supporting, organized by people recovering from a substance use problem themselves, and tend to have a disease model perspective advocating complete abstinence for their members/attendees.

For more information on specific treatments for substance use problems, please see the section Treatment Issues with Mental Health and Substance Use Problems.

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Difficulty Managing
Experience, Emotions

May
Start Here

Skills Erode

Use of Alcohol or
Other Drugs

Decrease Time
Using Other Skills

Short Term Effects

Increase Time
Using Drug
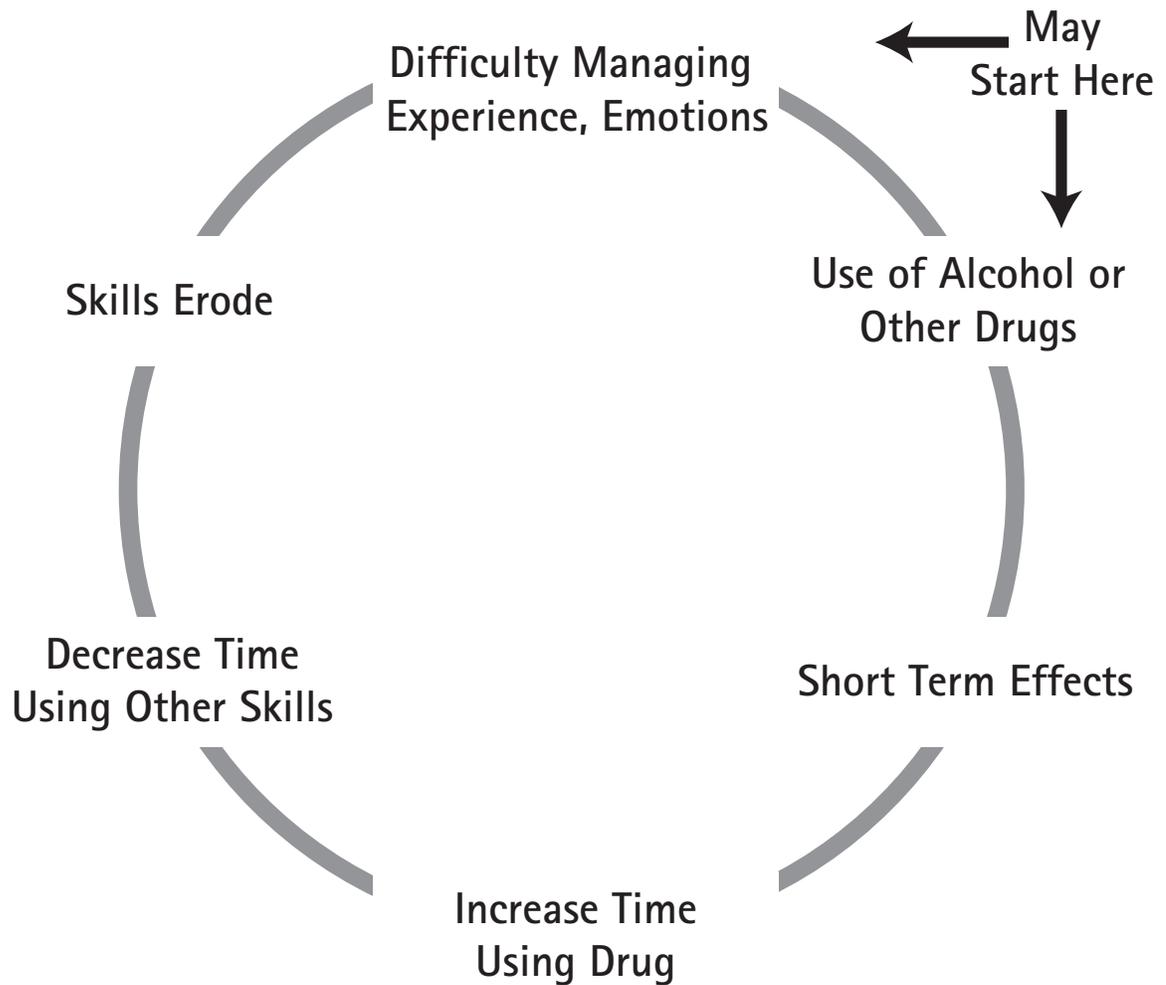
Do You Know... Methadone

Street Names: juice, meth (also used to refer to methamphetamines)

What is it?

Methadone belongs to the opioid family of drugs. It is used most commonly to treat dependence on other opioid drugs such as heroin, codeine and morphine.

Methadone is a synthetic opioid, which means that it is made from chemicals in a lab. Other opioid drugs include the opiates, such as morphine and codeine, which are natural products of the opium poppy, and semi-synthetic opioids, such as heroin, which is morphine that has been chemically processed.

Methadone was developed in Germany during the Second World War and was first used to provide pain relief.

Methadone maintenance treatment, which prevents opioid withdrawal and reduces or eliminates drug cravings, was first developed in the 1960s. For many years, Canadian regulations around the prescription of methadone were so restrictive that few doctors offered the treatment. People who wanted methadone treatment often had to wait months or years. In the 1990s, the need to reduce the harm of drug use was more clearly recognized, and changes were made to make it easier for doctors to provide methadone treatment. This has led to an increase in the number of people receiving treatment, and a decrease in the number of heroin-related deaths.

Methadone maintenance is not a cure; it is a treatment. Through treatment, people who are dependent on opioids receive the medical and social support they need to stabilize and improve their lives. They are encouraged to stay in treatment for as long as it helps them.

What Does Methadone Look Like?

Pure methadone is a white crystalline powder. The powder is dissolved, usually in a fruit-flavoured drink, and is taken orally once a day.

Who Uses Methadone?

Most people who are prescribed methadone are being treated for dependence on opioid drugs. This includes people who are dependent on illicit opioids, such as heroin, and also prescription opioids, such as codeine. Women who use opioid drugs regularly and who are pregnant are often treated with methadone to protect the fetus. Short-acting opioids such as heroin must be taken frequently to avoid withdrawal. Opioid withdrawal increases the risk of miscarriage or premature birth. Methadone maintenance, combined with medical care, improves the chances of having a healthy baby. There are no known long-term effects of methadone on the baby.

People who use opioid drugs regularly, and who are infected with HIV or hepatitis C, are prescribed methadone treatment to help protect their health, and to reduce the risk of spreading infection through needle sharing. Methadone is sometimes used to provide pain relief for people who have severe chronic pain or pain associated with terminal illness.

How Does Methadone Make You Feel?

When people begin methadone treatment, some experience the euphoria and sedation that are common to all opioid drugs. As treatment continues, and a stable dose of methadone is established, tolerance to these effects develops. Those in treatment often describe the feeling of being on methadone as "normal." Methadone treatment does not interfere with their thinking. They can work, go to school or care for family. Methadone also blocks the euphoric effect of heroin and other opioids, and in this way reduces the use of these drugs.

Most people experience some side effects from methadone treatment. Possible side effects include sweating, constipation and weight gain.

How Long Does The Effect Last?

A person who is opioid-dependent is kept free of withdrawal symptoms for 24 hours with a single dose of methadone. In contrast, a person who uses heroin to avoid withdrawal must use three to four times a day.

Daily treatment with methadone may continue indefinitely. If, however, the person taking methadone and his or her doctor agree to move toward ending treatment, the methadone dose is tapered down gradually over many weeks or months, easing the process of withdrawal.

If methadone is stopped abruptly, symptoms such as stomach cramps, diarrhea and muscle and bone ache will occur. These symptoms begin within one to three days after the last dose, peak at three to five days, and then gradually subside, although other symptoms such as sleep problems and drug cravings may continue for months.

Is Methadone Dangerous?

When methadone is taken as prescribed, it is very safe and will not cause any damage to internal organs or thinking, even when taken daily for many years. On the other hand, methadone is a powerful drug and can be extremely dangerous to people who do not take it regularly, as they have no tolerance for its effects. Even a small amount may be fatal for a child. For this reason, the dispensing of methadone is carefully monitored and controlled.

An important benefit of methadone treatment is that it reduces heroin use. The dangers of heroin use include death by overdose, and becoming infected, through needle sharing, with viruses such as HIV and hepatitis C. Methadone treatment helps to protect people from heroin-related tragedies.

Is Methadone Addictive?

Modern definitions of "addiction" look at many factors in assessing a person's drug use. These include "tolerance," or the need to use increasing amounts to achieve the same effect; "physical dependence," resulting in withdrawal symptoms if drug use is stopped; and "compulsive use," despite the negative consequences of continuing to use the drug.

Some people say that methadone is just as "addictive" as heroin. People in methadone treatment do become tolerant to certain effects of the drug, and will experience withdrawal if they do not take their regular dose. But methadone fails to meet a full definition of "addictive" when we look at how and why the drug is used.

First of all, methadone maintenance is offered as a medical treatment, and is prescribed only to people who are already dependent on opioid drugs. For these people, methadone provides a safe alternative to the routine danger and desperation of securing a steady supply of street drugs such as heroin. It frees them from the nagging compulsion to use, and allows them a chance to focus on improving their lives.

Methadone is sometimes used as a street drug, but when it is, it is usually taken to prevent symptoms of heroin withdrawal. The effects of methadone come on too slowly and last too long to give it much appeal as a substance of abuse.

What Are The Long-term Effects Of Methadone?

Methadone maintenance is a long-term treatment. Length of treatment varies, from a year or two to 20 years or more. This prolonged treatment with proper doses of methadone is medically safe and is the most effective treatment currently available for opioid dependence.

Used with permission from Centre for Addiction and Mental Health. Available at:
http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/methadone_dyk.html.

Making Connections: Women's Experience Of Violence, Mental Health And Substance Use Problems

"I look at the use of substances, stress levels and experience of violence as all facets of the same problem, they are all connected." (Woman Survivor in Greaves et al 2006).

This information sheet highlights the compelling evidence that women's mental health problems and substance use are linked to their experiences of woman abuse, sexual assault and other forms of gender-based violence and trauma. Women's experiences of violence and mental health/substance use problems are also linked to a host of other influences on their health and safety, connected primarily to gendered inequality in society.

Service providers and policy makers have not always acted on the known connections between mental health, substance use and violence, and as a result women have not always received the support they need. This sheet aims to provide evidence of the interconnections between these aspects of women's experience in order to support practitioners to be more confident in working with women in ways that are sensitized to these links. Women with interconnecting issues tell us that they want help in making the links themselves. We suggest that by working in partnership, anti-violence, mental health and drug and alcohol service providers can improve the provision of support to women who have these intersecting experiences.

Mental Health Problems And Experiences Of Woman Abuse, Sexual Assault And Other Forms Of Trauma

There is now substantial evidence that the stress caused by trauma can affect all aspects of a person's life including their emotional, mental and physical health and wellbeing. For women with trauma histories, the risk of developing mental health problems as an adult is heightened. This is true for:
- depression (Bassuk et al 1998)
- posttraumatic stress (Bassuk et al 1998; van der Kolk 1996)
- suicidal ideations and attempts (Bassuk, Melnick and Browne 1998)
- poor self-esteem (Herman 1992)
- eating disorders (Herman 1992)
- self-inflicted injury (Alexander and Muenzenmaier 1998)
- psychosis (Reid et al 2005)
- chronic medical conditions (Bassuk et al 1998)

For example, recent research shows that prolonged trauma may disrupt and alter brain chemistry, leading to the development of PTSD (Haskell 2003; Herman 1992; Levine 2005). In addition to this, mental health problems such as depression, suicide attempts and self-harm are frequently *symptoms of current abuse.* Pre-existing mental health problems can also be exacerbated by abuse and violence. Research also indicates that women who experience abuse and violence see direct, causal connections between these experiences and their mental health (Humphreys and Thiara 2003).

Depression and Violence links: Cascardi et al (1999) and Golding (1999) both undertook overviews of studies examining the relationship between depression and violence against women. Cascardi et al found that across the 14 studies the prevalence of depression amongst abused women was 38%-83%, depending on the study location. Golding found an average prevalence rate of depression amongst abused women of 47.6%. This compares with a prevalence rate of 10% in general populations of women.

PTSD and Violence links: The same authors reviewed the research evidence connecting the diagnosis of PTSD in women exposed to violence in their relationships. These US studies again showed very high rates of PTSD, varying from 31% to 84% (again depending on where the sample was drawn from).

Suicide and Violence links: Golding (1999) again has examined the connections between violence and suicide for women and describes significantly heightened rates of suicide attempts amongst abused women. Stark and Flitcraft (1995), doing US based research, report that of 176 women identified through medical records at an accident and emergency service, 52 (30%) had experienced violence in their relationships during the sample year. For Black women the rates were considerably higher than for white women.

While these links may appear to be obvious, they are often lost when a woman becomes involved in mental health services.

Substance Use And Experiences Of Woman Abuse, Sexual Assault And Other Forms Of Trauma

Many women identify their substance use (both legal and illegal) as a way to cope with their experiences of violence.

- Women identify that they drink more after a violent incident (Logan et al 2002)
- Women who are victims of serious child physical assault are significantly more likely to abuse prescription drugs, illegal drugs and alcohol (Logan et al 2002)
- An earlier experience of violence has been found to be associated with a younger age of initiating drug and alcohol use (NCASA 2003)

Women's substance use has also been found to be associated with current or historical experiences of woman abuse, sexual assault and other forms of trauma. For example:
- 30%-59% of women with substance use problems have Posttraumatic Stress Disorder (PTSD), most highly associated with repeated childhood sexual or physical abuse (Logan et al 2002).
- Alcohol problems have been found to be up to 15 times higher among women who are survivors of intimate partner violence than in the general population (Logan et al 202).
- Women who have experienced intimate partner violence have also been found to have a higher likelihood of depression (26.3% higher), and posttraumatic stress disorder (53.4% higher), as well as alcohol use problems (12.2% higher) (Logan et al 2002).
- As many as 2/3 of women entering treatment for substance use problems have a history of abuse or assault (Logan et al 2002).

These connections can be stronger for sub-groups of women such as women who are young (NCASA 2003; Silverman 2001), incarcerated (Dell 2006), Aboriginal (Bopp et al 2006), poor (Logan et al 2002; Salomon 2002), disabled (Chappell 1995) and/or refugees (Health Canada 1996; Vissandjee 2005).

Learning from SAMHSA's "Women with histories of physical and sexual abuse and co–occurring disorders" Study

This study was a five-year trauma intervention study on women with histories of physical and sexual abuse and mental health and substance abuse disorders. The study developed gender-specific, trauma informed, integrated and comprehensive service interventions and examined the effectiveness of these services in reducing signs and symptoms of trauma, mental illness and substance abuse for women. The background information collected from the women at the start of the study shows how interrelated trauma, mental health and substance use issues were for the 2,729 women involved:

Mental health
- 81% had a current mental health diagnosis
- 65% were receiving treatment
- 49% had been treated in psychiatric hospital or ward of general hospital for mental health problems

Trauma
- 85% had been physically abused
- 82% had been sexually abused, and 12% within the last 6 months
- 48% had been robbed, mugged or physically attacked by a stranger, and 8% within the past 6 months.

Substance use
- 99% used alcohol, marijuana, or crack/cocaine
- 45% used alcohol, and 60% used at least one drug in the past 30 days

Other
- 48% serious physical illness/disability
- 50% in residential services
- 24% unemployed and disabled

The study found that substance use symptoms and posttraumatic symptoms were significantly improved in intervention sites with some reduction of mental health symptoms. Women participants rated being happy and having healthy relationships as more important than reduction of symptoms. There were no significant differences in total costs in the intervention sites. A further major finding was that integrated counselling in a trauma informed context (receiving all three types of services in individual and/or group counselling) was associated with improved outcomes rather than an increased number of services (Salasin and Veysey 2007).

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Intake Form

PERSONAL DETAILS

Name: Date:

Address:

In case of emergency contact:

Home Phone: Date of Birth:

Alternate contact phone:

Physician name: Phone No:

Other service providers (e.g. therapist, mental health team, social workers, support group facilitator):

Name: Phone No:

Any special contact instructions or cautions:

Primary Language Spoken: | Access issues:

CAUTIONS

People who may pose a risk to the client or her dependents (names and relevant information):

CURRENT LIVING SITUATION

Other adults in the home (relationship to client):

Children in the home: Names, relationship to client, age, gender

SIGNIFICANT MEDICAL HISTORY

Any medical conditions:

Current treatment and medications:

Physical limitations or concerns:

Other medical/physical or health related issues (not directly mental health or substance use as these covered below e.g. tiredness, lethargy, poor sleep, lack of appetite):

TRAUMA HISTORY

Current trauma and abuse:

Current risks to client:

Current risks to dependent others:

Past adult trauma history:

Any contact with the police or legal system:

Outcomes:

MENTAL HEALTH HISTORY

Contacts with mental health professionals:

Current contact?

Hospitalizations for mental health problems:

Recent admissions?

History of suicide attempts:

Recent attempts?

Actions following?

History of self-harm:

Recent harm to self?

Actions following?

History of violence towards others:

Recent? Actions following?

Current psychiatric medications (antidepressants, sleeping medications etc):

Any known side effects/unwanted effects of medication:

SUBSTANCE USE

History of problems with substance use (include alcohol, street drugs and prescribed and over the counter medications and all use not just dependency related):

Current substance use (as above):

How frequently are they used?

Does she see her current substance use as problematic in any way?

If she sees her substance use as problematic what are the triggers for her use? How can the service help her handle or avoid these triggers?

Does she see any connections between problem use and other life areas such as experience of violence?

What is she doing to take care of herself and does she wish any help with addressing substance use problems at this time?

Self–Report Checklist Of Warning Signs: Do You Have An Alcohol Or Drug Problem?

Excerpted with permission from What A Woman Should Know: Alcohol and Other Drugs, by the Alberta Alcohol and Drug Abuse Commission. Available at http://www.aadac.com/547_1190.asp.

Here is a checklist of some warning signs that may suggest an alcohol or other drug problem. Please check the statements that relate to you:

○ I feel guilty about my use of substances, or what I do when drinking/using.

○ I sometimes have "blackouts" after drinking/using
(times when I later can't remember what I did or said).

○ I am drinking or using drugs more often, or it takes more of the substance to get me "high."

○ I have tried and failed to cut down on my alcohol or drug use.

○ Someone close to me has told me they are worried about my alcohol or other drug use.

○ I am sometimes unable to meet work, school or home obligations because of my substance use.

○ I have had legal problems as a result of my alcohol or other drug use.

○ I drink or use drugs to help me deal with my painful feelings.

○ I sometimes drink/use more heavily after disappointments or quarrels,
or when I am under pressure.

○ I can't imagine coping with life without alcohol or drugs.

○ Sometimes I lie or cover up my alcohol or drug use.

○ My alcohol or other drug use is affecting the way I parent my children.

If you checked off any of these boxes, your substance use is likely to be causing problems in your life. There is help and support available to you no matter what kind of problems you may have. Please talk to us so that we can help you.

Risk And Importance Summary

Client Name: **Agency:**

Date: **Prepared by:**

1. MENTAL HEALTH

Depression	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Anxiety	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Panic	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Post Traumatic Stress Disorder (PTSD)	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Mania	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Schizophrenia	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Eating problems	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Suicide	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Self Harm	High	Medium	Low
Risk to safety			
Woman's perception of importance			

This box is for other mental health problems relevant to the woman you are working with – please add in details

	High	Medium	Low
Risk to safety			
Woman's perception of importance			
	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Additional comments:

2. TRAUMA

Childhood Trauma History	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Sexual Assault/Rape	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Violence in relationships	High	Medium	Low
Risk to safety			
Woman's perception of importance			

This box is for other trauma relevant to the woman you are working with – please add in details

	High	Medium	Low
Risk to safety			
Woman's perception of importance			
	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Additional comments:

3. SUBSTANCE USE

Alcohol	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Street Drugs	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Prescription Drugs	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Over the Counter Drugs	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Overdose Risk	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Other problems or dangers – please add in

	High	Medium	Low
Risk to safety			
Woman's perception of importance			
	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Additional comments:

4. OTHER HEALTH PROBLEMS OR DISABILITIES

Ongoing Medical Difficulties	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Physical Restrictions or Disabilities	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Learning or Cognitive Disabilities	High	Medium	Low
Risk to safety			
Woman's perception of importance			

FASD	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Other disabilities or health concerns – please add in

	High	Medium	Low
Risk to safety			
Woman's perception of importance			
	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Additional comments:

5. LIFE SITUATION

Housing Difficulties	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Financial/Employment Difficulties	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Inadequate Social Support	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Inadequate Parenting Support	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Other specific life concerns – please add in

	High	Medium	Low
Risk to safety			
Woman's perception of importance			
	High	Medium	Low
Risk to safety			
Woman's perception of importance			

Additional comments:

Mental Health And Substance Use Safety Assessment Form

Name: Date

Date for review of the safety/risk assessment:

Significant Risk Factors	Brief Comment	General Risk Factors	Brief Comment
SUICIDE		SUBSTANCE USE RISKS	
Current mental health problem		Current harmful substance use	
Depressive illness		Using with unsafe others	
Previous attempts		Living with someone with a substance use problem	
Method(s) used		Poly-substance use (variety of substances used)	
Expressing suicidal ideas now		History of trying to cut down or withdraw from alcohol/drugs	
Has a plan made/is making plans		Experience of blackouts (losing memory when using substances)	
Self neglect		History of overdose	

Significant Risk Factors	Brief Comment	General Risk Factors	Brief Comment
Significant other has suicided		Impaired drinking charge	
May be impulsive		Accidents associated with substance use	
Uses substances		Unsafe injecting use	
Any recent losses or anniversaries of losses		Positive Virology (e.g. Hep B/C, TB, HIV)	
SELF HARM		**OTHER RISKS**	
History of self harming		Other current serious health problems/ disabilities	
Current self harming		Current major financial problems	
Hospitalized due to self harm		Homeless or poor/ unsafe housing	
Woman's self harm could have fatal consequences		Poverty/lack of resources in many areas of life	
		Involvement in the sex trade/survival sex	

Significant Risk Factors	Brief Comment	General Risk Factors	Brief Comment
RISK TO OTHERS		**SPECIFIC VULNERABILITIES**	
History of being violent/ serious harming another		Few or no friends or family members to turn to for help	
Expressing current intent to harm another		Few or no community connections or supports	
Risk of harm to children		History of trauma	
Experiencing extreme mental health crisis involving paranoia or other fears		Language or cultural factors that affect safety	

Consider:
- How important/dangerous does the woman feel these risks are?
- How does she currently manage these risks?
- How does she want help to manage these risks?
- What can you and your agency do to help address these risks with her? Are there other agencies that could help here?
- Actions to be taken and by whom? Including a plan for the woman if she is prepared to work in this way (this could also be addressed in her safety plan, including taking a harm reduction approach).

Note: Safety/risk assessments should be done on an ongoing basis: circumstances may change frequently. Record the risk assessment in a woman's file and include information on any incidents that occur that relate to risk.

A Simple Assessment
For Self-Harm Behaviour

1. The behaviour(s)
What are the self-harming behaviours that the client is doing?

2. How does this behaviour help the client? What problem(s) does it solve?
Ask the client for specific examples. Some clients may use one behaviour for one purpose and another behaviour for another purpose.
- Expresses strong feelings, e.g. anger
- Punishes self (especially before someone else can)
- Blocks strong feelings (serves as a distraction, uses physical pain to block emotions, thoughts, memories)
- Manages behaviour (stops one from doing something else, e.g. suicide)
- Creates or strengthens dissociation
- Helps client to stop dissociating, to feel more real
- Helps client to re-enact the trauma without consciously remembering it
- Strengthens the client's feelings of self-control over her body
- Helps reinforce internal rules, e.g. I don't need anyone, I have no desires
- Gives expression to a state that seems to have no feelings
- Other

3. What is the client's cycle of SELF-HARM AND WHAT IS THE WINDOW of intervention?

Critical Incident Report—Suicidal Intention

Date: _____ Time: _____

Counsellor Name: _____

Client Name: _____ Phone Number: _____

Situation: _____

Level of Risk Designated:

RISK LEVELS

LOW	MODERATE	HIGH (Imminent)
◯ Suicidal ideation	◯ Suicidal intent	◯ Determined suicide intent
◯ No clear plan	◯ May have plan, but vague	◯ Plan includes how, when and where
◯ No established means of attempting suicide	◯ May have means to carry out suicide	◯ Means of intent has high degree of lethality
◯ Support available	◯ Possible supports available	◯ No perceived supports
◯ Sense of hopelessness, but strong future orientation	◯ Hopeless, but has some future orientation	◯ No future orientation

Other Indicators of Risk (e.g. previous attempts, suicides or attempts by family or close friends, important anniversary dates, a number of personal losses):

Contra–Indicators of Risk (strengths and resiliencies):

Action Taken:

Signed: _____ Date: _____

Ways To Try To Prevent A Suicide Attempt

If you are concerned that someone may be suicidal, take action. If possible, talk with the person directly. The single most important thing you can do is to listen attentively without judgement.

Talking about suicide can only decrease the likelihood that someone will act on suicidal feelings. There is almost no risk that raising the topic with someone who is not considering suicide will prompt him/her to do it.

Find a safe place to talk with the person, and allow as much time as necessary. Assure him/her of your concern and your respect for his/her privacy. Ask the person about recent events, and encourage him/her to express his/her feelings freely. Do not minimize the feelings involved.

Ask whether the person feels desperate enough to consider suicide. If the answer is yes, ask, "Do you have a plan? How and where do you intend to kill yourself?"

Admit your own concern and fear if the person tells you that he/she is thinking about suicide but do not react by saying, "You shouldn't be having these thoughts; things can't be that bad."

Remember, you are being trusted with someone's deepest feelings. Although it may upset you, talking about those feelings will bring the person relief.

Ask if there is anything you can do. Talk about resources that can be drawn on (family, friends, community agencies, crisis centres) to provide support, practical assistance, counselling or treatment.

Make a plan with the person for the next few hours or days. Make contacts with him/her or on his/her behalf. If possible, go with the person to get help.

Let the person know when you can be available, and then make sure you are available at those times. Also, make sure your limits are known, and try to arrange that there is always someone that he/she can call at any time of day.

Ask who else knows about the suicidal feelings. Are there other people who should know? Is the person willing to tell them? Unfortunately, not everyone will treat this issue sensitively.

Confidentiality is important, but do not keep the situation secret if a life is clearly in danger.

Stay in touch to see how he/she is doing. Praise the person for having the courage to trust you and for continuing to live and struggle.

What to do following a suicide attempt

A person may try to commit suicide without warning or despite efforts to help. If you are involved in giving first aid, make every effort to be calm and reassuring, and get medical help immediately.

The time following an attempt is critical. The person should receive intensive care during this time. Maintain regular contact, and work with the person to organize support. It is vital that he/she does not feel cut off or shunned as a result of attempting suicide.

Be aware that if someone is intent on dying you may not be able to stop it from happening. You cannot and should not carry the responsibility for someone else's choice.

Safety Planning For
A Survivor Of Violence

The suggestions in this document represent some safety tips learned from women dealing with abusive current and former partners. It is critical that documents such as this are used in a way that acknowledges and builds on a woman's knowledge of her own unique situation. There are suggestions in this document that will work for some women, but that could be extremely unsafe or unrealistic for others. Equally important is the fact that a woman is likely already doing things to keep herself/her children safe that are not included in this document.

Survivors and front-line workers with extensive experience in safety planning advise that documents listing options for safety planning should not be used as checklists to be reviewed with a survivor.

Documents listing options for safety planning should be used as a tool to assist you, the front-line worker, to consider a broad range of possibilities in assisting a woman to plan for her safety. It may be helpful to review this document first for yourself, set it aside and engage in your safety planning with the woman, then consult it later to see if there are other options that have not been addressed.

- Trust your intuition, instincts and experiences; do not doubt yourself if you feel unsafe.

- Practice how to get out of your home safely. What doors, window, elevators, stairwells or fire escapes could you use? If appropriate, practice with your children.

- Alert your neighbours to call the police if they hear a fight.

- Choose a code word to use with children, friends and/or family so they can call for help.

- If an assault seems possible, try to move to a space that is lowest risk (try to avoid bathrooms, garages, kitchens, rooms near weapons and rooms without access to an outside door).

- Plan ahead for where to go in an emergency (explore possibilities, including family, friends and local transition houses/safe homes).

- Find someone who will support and listen to you without making judgments.

- Keep extra car keys, money and clothes in a hidden place or at a friend's.

- Seek medical attention for all injuries. Be aware that you may have suffered physical damage you are not aware of, such as internal bleeding or concussions.

- Ensure that colour photographs are taken of all injuries. It is important to take pictures as injuries change in appearance, such as bruising that appears some time after an assault.

- Save torn or bloody clothing.

- Report assaults to the police (be aware that the police must proceed with recommending charges if there is evidence to do so, regardless of your wishes).

- Preserve evidence such as written notes of apology, bank statements, and other documents.

- Record abusive incidents in a journal; keep the journal in a secret spot. Do not give your journal to anyone unless subpoenaed to do so. If you give your journal to Crown counsel, they are required to turn it over to defence and you may be cross-examined on it.

- Keep a list of names and numbers of all people who have witnessed any abuse or threats (their evidence may be useful later).

- Familiarize yourself with family finances.

- If necessary, find out if you would qualify for social assistance and how much money you would have to live on.

- If necessary, take courses or re-enter the work force. If that is necessary but not possible in your situation, familiarize yourself with courses and job training that would be available if your situation changed.

If separating:

- It may not be safe to tell your partner you are leaving. Some possibilities for leaving include when your partner is in the shower, asleep, at work or out of town, or when you are picking up children from school, going to medical appointments or going to work.

- If you have children, take them with you when you leave. Take copies of children's medical papers, birth certificates and other important documents.

- Keep change or a pre-paid phone card available for telephone calls (if you use telephone credit cards, the following month the bill will tell your partner/ex-partner which numbers you called).

- Take copies of important documents/items with you when you leave. If you are planning to leave, put these items in one place if possible. Some important documents/items include:

○ Personal identification	○ Address book
○ Children's birth certificates	○ Pictures
○ Your birth certificate	○ Jewellery
○ Social Insurance cards	○ Children's favourite toys and/or blankets
○ School and vaccination records	○ Items of special sentimental value
○ Checkbook	○ Divorce papers
○ ATM card	○ Medical records
○ Credit cards	○ Bank books
○ Keys–house/car/office	○ Previous tax returns
○ Driver's license and registration	○ Insurance papers
○ Medications	○ Small saleable objects
○ Social assistance identification	○ List of important phone numbers
○ Work permits	○ Citizenship papers
○ Landed immigrant papers	○ Passports
○ Lease/rental agreement, house deed, mortgage papers	

If separated:

- Change the locks on doors and windows.

- Replace wooden doors with steel/metal doors.

- Install security measures such as additional locks, window bars, poles to wedge against doors, an electronic alarm system, etc.

- Purchase rope ladders for escape from second floor windows.

- Install smoke detectors and purchase fire extinguishers for each floor in your home.

- Install an outside lighting system that lights up when a person is coming close to your home.

- Inform your employer of your situation.

- Change your route to work.

- Change your start and end time at work.

- Walk with someone to your car.

- If your partner follows you, drive to a place where there are people.

- Use different grocery stores, shopping malls and banks than those you used when residing with your partner.

- Change the hours you conduct your shopping/banking.

- Teach your children how to make a collect call to you and to a trusted family member or friend, in the event that your ex-partner takes the children.

- Tell people who take care of your children which people have permission to pick up the children, and that your ex-partner is not permitted to.

- Inform your neighbours that your ex-partner no longer lives with you and to call the police if he is seen near your residence.

- Keep a copy of any protection orders with you at all times.

- Inform necessary people that you have a protection order (employer, children's schools, child care).

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SECTION 6

Increasing Control Over Your Feelings

Dimmer switch

Visualize a dial with numbers on it from 0 to 10. A number controls the intensity of whatever feeling you are having. Perhaps you are feeling sad. Imagine turning the dial toward 0 and turning down the intensity of your sadness, just as you could dim the intensity of light with a dimmer switch. A dimmer switch lessens the amount of electrical energy that can be emitted. Imagine you have the capacity to lessen the amount of energy that is expressed in your sadness. Allow yourself to slowly and gradually diminish the feeling.

Remote control

This device can be used to control the intensity of intrusive images or sounds. Imagine changing channels, switching from disturbing images to soothing images. You may want to develop a "safe place" channel and run an imaginary video of the safe place you created. You can use your remote to decrease the volume of sounds or voices you hear in your head or fast forward through a flashback.

Riding a train

Imagine you are on a comfortable seat in a train, going on a journey. You are sitting back, looking out the window at the landscape. The landscape is made up of your emotional feelings. You can watch your feelings pass by as you sit comfortably in your seat. You can look out with curiosity and bring feelings closer to you. You can make them small and distant like a speck on the horizon. Or you can choose to close your eyes and just feel the comfortable motion of the train on the tracks, knowing that you are in motion and that your feelings too will pass by, just like the scenery out the window.

Split screen

This skill is like watching a television screen where two consecutive programs are playing. Divide a mental TV screen, putting the past on one side and the present on the other. You have the remote control that allows you to mute, slow down, fast forward, pause, turn to black and white, or turn off the program completely. You can download the disturbing memories to a videotape for three seconds. You can then turn off the TV, take out the tape and store or file it in a safe place.

The videotape (especially helpful with memories)

Your feeling is on this videotape. You have the remote control in your hand. At any time, you can turn it on or off, change the volume, pause it, fast forward or rewind it, hit the mute button or take the tape out and pack it away in a secure place.

The audio tape

Visualize a cassette tape player. Your emotion is on the cassette. You can shut it off. You can turn the volume down so you can't hear it. Turn it up a tiny bit, so you can barely hear it. Turn it up another bit, so it is very soft. Turn it down again. Practice until you are ready to turn it up just enough to hear it. Remember, you can turn it off or down whenever you want.

The Differences Between Dissociation And Self-Awareness

Dissociation/Avoidance/Numbing

- makes you unaware of what's going on inside you
- makes you feel safe but does not make you safe
- makes it hard to solve problems
- reduces your self-control
- limits your access to your feelings

add your own differences here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Self-Awareness

- makes you aware of what's going on inside you
- increases your safety by making you aware of resources
- increases your awareness of choices
- increases your self-control
- gives you access to your feelings

add your own differences here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Relapse Prevention

Relapse (stepping back into old behaviours after a time of recovery) happens when we are on a healing journey. We may relapse into using substances, into self-harming behaviours or into old thinking patterns. The purpose of this worksheet is to identify your relapse triggers, develop a personalized relapse prevention strategy and plan for success.

Identifying Triggers

Relapse triggers can include **feelings** (e.g. anger, loneliness); certain **people** (e.g. friends who are still using); **situations** (e.g. a party or dealing with Ministry personnel, police, etc.)

Identify what your triggers are:

Feelings:
_____
_____
_____
_____
_____

Situations:
_____
_____
_____
_____
_____

People:
_____
_____
_____
_____
_____

If you are to break the cycle of active use or self harm, you must choose differently when triggered to use or harm. By doing this, you will learn other ways of dealing with the triggers, rather than picking up. You will need to have a plan in place. This involves identifying things you can do instead of using or harming yourself.

Dealing With Triggers And Cravings

I can do the following things when triggered instead of using/ harming:

1. _____
2. _____
3. _____
4. _____
5. _____

These five people support my recovery and I can call them if I need to:

1. _____
2. _____
3. _____
4. _____
5. _____

These are non-using/harming activities that I would like to do (e.g. swimming, reading, working out, going to movies, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____

Plan For Success

Plan your day! Include schedules, activities, meetings, and some of the non-using activities you have identified. Consider investing in an inexpensive day planner. All of these tools will allow you to be in control of your time and your day and reduce the risk of relapse.

Key Points about Red and Green Flags

Adapted from: Seeking Safety. Lisa M. Najavits. Guildford Press. 2002.

Red flags are messages of distress. Just as a fever is a sign that you must rest your body, red flags are signs that you are in emotional distress. With PTSD and substance abuse, the tendency is to push them out of your mind, not seeing the signs as they occur. But it is essential to notice the red flags and to validate that they are there for a reason; they are not signs of weakness or failure, but messages to attend to yourself.

Remember "budding." Some people are helped by the acronym BUD: Building Up to Drinking. You could also use Building Up to Danger. The list of red flags in Signs of Danger Versus Safety (next page) can be a sign that you are gearing up to act destructively. There is a window of opportunity during which you can stop yourself from sliding downhill if you can see the warning signs and actively try to cope with them. Thus dangerous times in both PTSD and substance abuse are not all-or-nothing events, but rather gradual build-ups that allow time to save yourself.

Help from others is essential as danger escalates. As red flags increase, the need to reach out for help from safe people increases too. One of the most difficult aspects of PTSD and substance abuse is isolation. As symptoms increase, the tendency is to hide away. That's why it is necessary to plan in advance whom you will call and to prepare that person for how to help you through a dangerous time. Rehearse what you will say to each other.

Listen to the "whispers" before they become "screams." A safety plan identifies your warning signs and ways to respond to them. The safety plan has three levels so that you can attend to mild danger signs (level 1) before they become an emergency (level 3). The earlier in the process you take action, the better.

As danger increases, so does acting out rather than talking. Notice that many of the danger signs are behaviours. As distress increases, it is essential to keep talking about your feelings; otherwise you'll likely find yourself "acting them out" in your behaviour. Think of a small child who feels hurt and starts punching a wall. When the child cannot express the feelings directly, they get acted out.

Most substance abuse relapses occur within 90 days of abstinence. Research shows the first 90 days to be a vulnerable time, across various substances of abuse (heroin, smoking, alcohol). Thus knowing your danger signs is especially important in early recovery.

Notice spiralling. In recovery, there is a process of "spiralling" or "snowballing" that can occur in both positive and negative directions. A downward spiral occurs when symptoms start to pick up speed and get worse and worse, often rapidly. An upward spiral occurs when your recovery efforts are so persistent that good things begin to happen. For example, you get a job, and are therefore able to get an apartment in a safer area, where you can make friends with healthier people, and so on...

SECTION 6

Signs Of Danger Versus Safety

Listen to the messages your behaviour is sending you! **What are your red and green flags? Check off below:**

Red Flags	Green Flags
Danger	**Safety**
☐ Isolation	☐ Spending time with supportive people
☐ Not taking care of my body (food, sleep)	☐ Taking care of my body
☐ Fights with people	☐ Able to get along
☐ Too much free time	☐ Structured schedule
☐ Destructive behaviour	☐ Behaviour under control
☐ Feel stuck	☐ Feel I am moving forward
☐ Lying	☐ Honest
☐ Negative feelings acted out	☐ Negative feelings expressed in words
☐ Cancelling treatment sessions	☐ Attending all treatment regularly
☐ Stop taking medications as prescribed (either too much or too little)	☐ Taking medications as prescribed
☐ Passive ("Why bother?")	☐ Active coping
☐ Cynical/negative	☐ Realistic/positive
☐ Not fighting PTSD symptoms (e.g. dissociation, self-cutting)	☐ Fighting PTSD symptoms (e.g. grounding, rethinking)
☐ Not learning new coping skills	☐ Learning new coping skills
☐ Become physically sick	☐ Stay physically healthy
☐ Believe treatment is unnecessary	☐ Believe treatment is necessary
☐ Spend time with people who use	☐ Spend time with "clean" people
☐ Cannot hear feedback	☐ Listen to feedback
☐ Too much responsibility	☐ Appropriate responsibility
☐ Think people are trying to make me look and feel bad	☐ Feel okay around people
☐ Stop caring, stop trying	☐ Care and try
☐ Arrogant euphoria	☐ Realistic concern
☐ Absent from work or school	☐ Attend work or school

What are your additional red flags?	What are your additional green flags?

Create A Safety Plan Against Relapsing

Fill In The Safety Plan Using The Following As An Example:

Mild Danger (Starting To Show Distress)	What I Will Do To Stay Safe
• Eating poorly • Missing occasional counselling sessions • Getting cynical and negative	• Increase support meetings to three times a week • Tell therapist what I am feeling • Call my friend Pat and talk with her

Red Flags	Safety Plan
Mild Danger (Starting To Show Distress)	**What I Will Do To Stay Safe**
Moderate Danger (Getting Serious—Watch Out)	**What I Will Do To Stay Safe**
Serious Danger (Emergency!)	**What I Will Do To Stay Safe**

Safe Coping Skills

Ask for help ▶ reach out to someone safe

Inspire yourself ▶ carry something positive

Make a switch ▶ if things are going wrong – switch gears

Persist ▶ never, never, never give up

Honesty ▶ honesty with self heals a lot

Cry ▶ let yourself cry, it won't last forever

Choose self–respect ▶ choose whatever will help you like yourself tomorrow

Take good care of your body ▶ healthy eating, exercise, sleep

List your options ▶ in any situation, you have choices

Create meaning ▶ remind yourself why you began this healing journey – for your children, for love, for truth, to live a full life?

Do the best you can with what you have ▶ make the most of every available opportunity

Set a boundary ▶ say no when you need to

Compassion ▶ listen to yourself with respect and care

Talk yourself through it ▶ positive self-talk helps in difficult situations

Imagine ▶ create a mental picture that makes you feel different – imagining your safe place

Notice that point of choice ▶ in slow motion, imagine the exact moment when your behavior takes a turn down the road you may not wish to follow

Pace yourself ▶ if overwhelmed – go slower, if stagnant – go faster

Seek understanding, not blame ▶ listen to your behavior and that of others – blaming prevents growth

If one way doesn't work, try another ▶ as if in a maze, turn a corner and try a new path

Create a new story ▶ you are the author of your own life. You are writing your own story

Avoid avoidable suffering ▶ try to prevent a bad situation

Ask others ▶ ask others if your beliefs are correct

Watch for the danger signs ▶ handle the problem before it becomes huge – notice the red flags

Healing above all ▶ focus on what really matters

Try something, anything ▶ a good plan today is better than the perfect plan tomorrow

Discovery ▶ find out if what you assume is true – become curious about your own reaction, be a detective digging into your own life

Create a buffer ▶ put something between you and the danger zone – time, distance etc

Say what you really think ▶ you'll feel closer to those you love when you can do this – ensure these people are safe people for you to be honest with

Listen to your needs ▶ no more neglect – really hear what you need

Replay the scene ▶ review the negative event – what can you do differently next time?

Move toward your opposite ▶ for example, if you are too dependent, try being independent or vice versa

Notice the cost ▶ what is the price of your reactions – for yourself, for others you care about?

Structure your days ▶ a productive schedule keeps you on track – remember to build in time to just be

Soothing talk ▶ talk to yourself very gently

Think of the consequences ▶ really see the impact of what you do today on tomorrow, next week, next year

Trust the process ▶ just keep moving forward – the only way out is through

Work the material ▶ the more you put into the healing process the more you get out

Integrate the split self ▶ accept all aspects of yourself – they are there for a reason

Expect this kind of growth to be uncomfortable at times ▶ if it feels awkward or difficult, it probably means that you're doing it right

Pretend you like yourself ▶ see how different the day feels

Focus on now ▶ do what you can to make today better, don't get overwhelmed by the past or future

SECTION 6

Praise yourself ▶ notice what you are doing right — this is the most powerful method of healing and growth

Observe repeated patterns ▶ try to notice and understand when the same things happen again and again

Self-nurture ▶ do something you really enjoy

Take responsibility ▶ take an active not a passive approach

Make a commitment ▶ to your own healing journey

Detach from emotional pain ▶ use grounding techniques to help

Learn from experience ▶ seek wisdom that will help next time

Solve the problem ▶ don't take it personally when things go wrong – just try to seek a solution

Use kinder language ▶ make your language to yourself and others less harsh

Plan it out ▶ take the time to think ahead

Identify the belief ▶ get curious about why you believe what you believe

Reward yourself ▶ find a healthy way to celebrate anything you do right

Create new tapes ▶ literally! Take a tape recorder and record your new way of thinking and play it back

Find rules to live by ▶ really think about choosing the rules that work for you and committing to those

Setbacks are not failures ▶ a setback is just that – nothing more

Tolerate the feelings ▶ no feeling is the final statement – just live through it steadily and safely

Actions first, feelings will follow ▶ don't wait until you feel motivated, just start now

Fight the trigger ▶ when you begin to recognize what triggers certain behaviours that you want to change – take a proactive stance to protect yourself

Make a decision ▶ if you feel stuck, try choosing the best solution you can think of right now; don't wait – you aren't perfect

Do the right thing ▶ do what you know will help, even if you don't feel like doing it

Prioritize healing ▶ make healing a most urgent and important goal – you're worth it!

Reach out for resources ▶ they're out there – lean on them

Get others to support your healing process ▶ tell people close to you what you need from them

Notice what you can control ▶ you are not in control of the whole world – keep this in mind

Coping With Triggers

A trigger is an experience that we associate with a past trauma that can cause the PTSD symptoms of intrusion, hyper-arousal and avoidance.

Changes in your body can occur from a trigger even when you don't remember the actual traumatic event.
- Learning to recognize signals in your body will help you cope with triggers.
- Substance use can be a way of avoiding triggers.
- You can be re-traumatized by triggers.

Examples of triggers are:
- Seeing your ex-partner
- Hearing ambulance sirens
- Smelling whiskey
- Having a pap test
- Tasting certain flavours
- Re-visiting your childhood home

Every time you overcome a trigger your ability to cope becomes stronger.

Suggestions For Coping With Triggers

Stay far away from triggers. The safest plan is to stay away from triggers whenever possible; for example, by not watching upsetting TV shows, staying away from bars, learning to avoid "avoidable suffering."

Don't "test yourself" with triggers. This is a mistake some people make in early recovery. They may think, "I'll go to a party tonight to see if I'm strong enough to tolerate drug triggers." Just as you would not test yourself by getting into a new trauma, avoid testing yourself with substance and high-risk behaviors. It is hard enough to recover without setting yourself up.

Triggers are part of life, but you can use your skills to cope with triggers you cannot avoid. Even if you do everything you can to avoid triggers, some will occur just because it is impossible to live in a bubble. As you go through your day, you will be faced with triggers at times. The important thing is to use coping skills when triggers do occur.

Avoid blaming others. When you feel triggered, learn to reflect inwards instead of lashing out. Try saying, "I am feeling triggered, I need to take care of myself."

Strive for balance. With PTSD you may feel too much at times (e.g. overwhelming, intense emotions) and too little at other times (e.g. numbness, dissociation). With substance use you may also feel too much (e.g. intense cravings) or too little (e.g. the "pink cloud" in which you feel you'll never be tempted to use again). To best fight triggers, the goal is balance: being aware, conscious, and in touch with reality so that triggers will not control you.

Cope with triggers before, during, or after they occur. Prepare to cope in advance, and at any time in the process. Never give up!

Triggers can be very sudden. That is what makes them so upsetting. They may appear when you least expect them.

Changing Who, What, And Where To Cope With Triggers

You Can Get To Safety By Changing Who, What And Where.

Who Are You With?

Detach from unsafe people (dealers, users and abusers). Move toward safe, positive people. Call your sponsor, or a safe friend or family member. Call before, during or after a trigger occurs (preferably before!). You can talk about how you are feeling, or just discuss "light" topics such as movies or sports to distract yourself. Also, stay connected with important people in your life by carrying photographs of them. If you get triggered, pull out the photos and ask yourself, "What do I need to do right now? How will my substance use affect them?"

What Are You Doing?

Switch to safe activities. Try reading, watching TV, listening to calming music, exercising, taking a walk or doing a craft or hobby. Keep busy in general by having a structured schedule that focuses your attention away from triggers.

Where Are You?

Change your environment. If you feel triggered, find a safe place by leaving the room, the area, or the neighborhood; taking a drive or a walk; throwing out the drug accessories; or changing the TV channel.

Using Grounding

What Is Grounding?

Grounding is a way of dealing with emotional pain. It helps you to be in present reality rather than in painful experiences from the past or scary thoughts of the future.

Grounding can help you find a balance between overwhelming emotions and the need to be numb or dissociated. When you are grounded you are conscious of reality and able to tolerate it.

Guidelines
- Grounding can be done *any time, any place, anywhere,* and no one has to know.
- *Focus on the present, not the past or future.*
- *Keep your eyes open, scan the room, and turn the light on* to stay in touch with the present.
- *Stay neutral* – avoid judgments of "good" and "bad." For example, instead of "The walls are blue; I don't like blue because it reminds me of depression," simply say, "The walls are blue" and move on.
- *Rate your mood before and after grounding,* to test whether it worked. Before grounding, rate your level of emotional pain (0-10, where 10 means extreme pain). Then re-rate it afterward. Has it gone down?
- Use grounding when you are *faced with a trigger, enraged, dissociating, having a substance craving, or whenever your emotional pain goes above 6 (on a 0-10 scale).* Grounding puts healthy distance between you and these feelings.
- *No talking about feelings or journal writing at this time*—you want to stay *away* from distressing feelings, not get in touch with them. Processing feelings can happen later.
- *Note that grounding is not the same as relaxation training.* Grounding is much more active, focuses on distraction strategies, and is intended to help extreme feelings. It is believed to be more effective than relaxation training for PTSD.

Ways Of Grounding

1. Mental grounding happens when you focus your mind. Two examples of this are:
   - Describe your environment in detail, using all your senses: for example, "The walls are white; there are five pink chairs; there is a wooden bookshelf against the wall..." Describe objects, sounds, textures, colors, smells, shapes, numbers, and temperature. You can do this anywhere. For example, on the bus: "I'm on the bus. I'll see the river soon. Those are the windows. This is the bench. The metal bar is silver. The bus map has four colors."
   - Describe an everyday activity in great detail. For example, describe a meal that you cook: "First I peel the potatoes and cut them into quarters; then I boil the water; then I make an herb marinade of oregano, basil, garlic, and olive oil..."

2. Physical grounding happens when you focus on your senses, like touch, sound and taste. Two examples of this are:
    *   Touch various objects around you: a pen, keys, your clothes, the table, the walls. Notice textures, colours, materials, weight, temperature. Compare objects you touch: Is one colder? Lighter?
    *   Focus on your breathing, noticing each inhale and exhale. Repeat a pleasant word to yourself on each inhale (e.g. a favourite colour, or a soothing word such as "safe" or "easy").

3. Soothing Grounding happens when you talk to yourself in a kind way. Two examples of this are:
    *   Say kind statements, as if you were talking to a small child—for example, "You are a good person going through a hard time. You'll get through this."
    *   Say a coping statement: "I can handle this," "This feeling will pass."

What If Grounding Does Not Work?

*   *Practice as often as possible,* even when you don't need it, so that you'll know it by heart.
*   *Try to notice which methods you like best*—physical, mental, or soothing grounding methods, or some combination.
*   *Create your own methods of grounding.* Any method you make up may be worth much more than those you read here, because it is yours.
*   *Start grounding early in a distressing mood cycle.* Start when a substance craving just starts or when you have just started having a flashback. Start before your anger gets out of control.
*   *Make up an index card* on which you list your best grounding methods and how long to use them.
*   *Have others assist you in grounding.* Teach friends or family about grounding, so that they can help guide you with it if you become overwhelmed.
*   *Prepare in advance.* Locate places at home, in your car, and at work where you have materials and reminders for grounding.
*   *Create a cassette tape of a grounding message* that you can play when needed. Consider asking your therapist or someone close to you to record it if you want to hear someone else's voice.
*   *Try grounding for a looooooonnnnnngggggggg time (20-30 minutes).* And repeat, repeat, repeat.
*   *Think about why grounding works.* Notice the methods that work for you—why might those be more powerful for you than other methods?
*   Don't give up!

Safety Plan For Women With Mental Health Concerns

If mental health issues occur alongside violence in my relationship with my partner, I can enhance my safety by doing some or all of the following:

I will remind myself that violence affects my stress levels and impairs my mental health so when I am in violent situations I need to be more watchful of my stress and mental health needs and remember to ask for help from:

_____

The following events almost always increase my stress and have a negative effect on my mental wellbeing:

_____
_____
_____
_____

The warning signs that I am getting stressed and moving into crisis are:

_____
_____
_____
_____

and this is what I will do in these situations to try to keep myself well/balanced
and to try to keep myself safe:

_____
_____
_____
_____

If I feel myself moving into a crisis state I can:

_____
_____
_____
_____

I can also:

_____
_____

I can call _____ for support when I feel emotionally distressed.

_____

The following people/places/things can be unsafe for me:

_____
_____
_____
_____

To safeguard my children I might

_____
_____
_____
_____

Other things I can do to help me feel stronger are
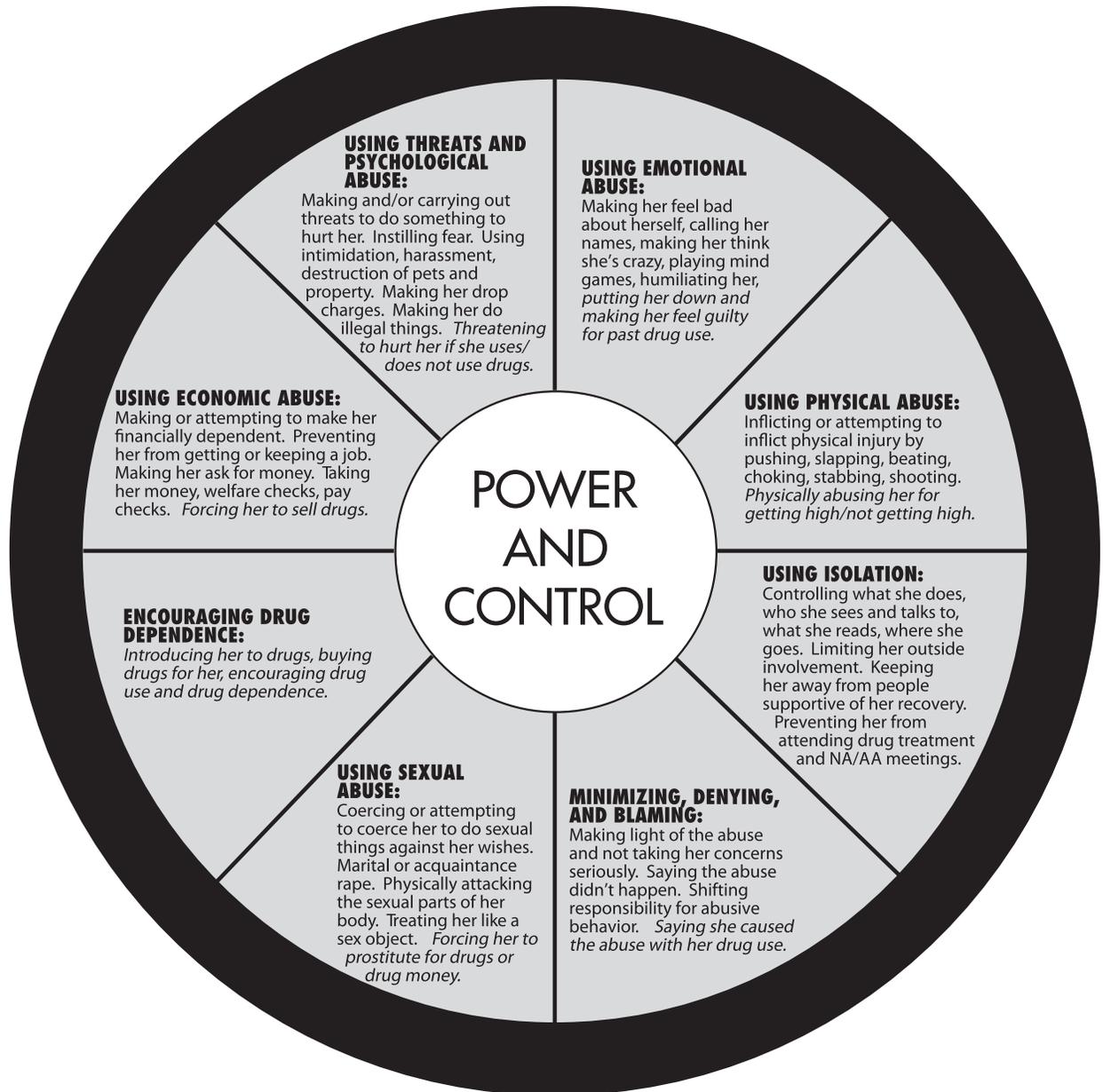
_____
_____
_____
_____

If there are additional supports you require for your mental health or substance use problem such as numbers of supportive professionals or advocates or medication, then make sure these are stored with other important documents and items that you can take with you in crisis situations when you need to leave your home quickly.

Keep an extra supply of medication alongside other critical items with a trusted friend or in a concealed place, easily accessible if you need to leave quickly.

Think about:

- Medications and prescriptions
- Information about services and benefits
- Names and phone numbers for case workers or other service providers who can help to coordinate services for you
- Health/life insurance papers
- Medical records

Power And Control Model For Women's Substance Abuse

USING THREATS AND PSYCHOLOGICAL ABUSE:
Making and/or carrying out threats to do something to hurt her. Instilling fear. Using intimidation, harassment, destruction of pets and property. Making her drop charges. Making her do illegal things. *Threatening to hurt her if she uses/ does not use drugs.*

USING EMOTIONAL ABUSE:
Making her feel bad about herself, calling her names, making her think she's crazy, playing mind games, humiliating her, *putting her down and making her feel guilty for past drug use.*

USING ECONOMIC ABUSE:
Making or attempting to make her financially dependent. Preventing her from getting or keeping a job. Making her ask for money. Taking her money, welfare checks, pay checks. *Forcing her to sell drugs.*

USING PHYSICAL ABUSE:
Inflicting or attempting to inflict physical injury by pushing, slapping, beating, choking, stabbing, shooting. *Physically abusing her for getting high/not getting high.*

POWER AND CONTROL

ENCOURAGING DRUG DEPENDENCE:
Introducing her to drugs, buying drugs for her, encouraging drug use and drug dependence.

USING ISOLATION:
Controlling what she does, who she sees and talks to, what she reads, where she goes. Limiting her outside involvement. Keeping her away from people supportive of her recovery. Preventing her from attending drug treatment and NA/AA meetings.

USING SEXUAL ABUSE:
Coercing or attempting to coerce her to do sexual things against her wishes. Marital or acquaintance rape. Physically attacking the sexual parts of her body. Treating her like a sex object. *Forcing her to prostitute for drugs or drug money.*

MINIMIZING, DENYING, AND BLAMING:
Making light of the abuse and not taking her concerns seriously. Saying the abuse didn't happen. Shifting responsibility for abusive behavior. *Saying she caused the abuse with her drug use.*

What Inspires
My Healing?

As we move along a healing path, sometimes it helps to remember why we are doing it. It is easy to make promises to ourselves, but keeping them can be a challenge when we are dealing with substance use and trauma symptoms. Healing can use all the motivation we can muster. In one direction is recovery, freedom from addiction, and light; the other direction offers continued addiction, a downward spiral, and darkness.

Describe what inspires your healing, rating each area on the following scale:

0	1	2	3
Not at all Important	A Little Important	Moderately Important	Extremely Important

Write a few lines under each area. For example, one woman wrote under "For my children":

My kids are my life. I want to give them the best that I can. If I can stop drinking, I can give them the life they deserve. It breaks my heart to think of what my addiction is doing to them.

If you enjoy being creative, you can copy this page and create a small inspiration book from it, adding additional pages with photographs of the people you love or other reminders to help you through healing. Some people add favourite quotations, poems, songs or pictures. A photo of yourself can also be a good reminder, such as a picture of you at your best, you as a child, or you at an important life event.

For my children/family   How important? 0 _ 1 _ 2 _ 3 _

_____

_____

_____

For my health   How important? 0 _ 1 _ 2 _ 3 _

_____

_____

_____

For my spirituality   How important? 0 _ 1 _ 2 _ 3 _

_____

_____

_____

For my relationships How important? **0** _ **1** _ **2** _ **3** _

_____
_____
_____

For my work How important? **0** _ **1** _ **2** _ **3** _

_____
_____
_____

To create a better life How important? **0** _ **1** _ **2** _ **3** _

_____
_____
_____

To treat myself with respect How important? **0** _ **1** _ **2** _ **3** _

_____
_____
_____

To give myself the childhood I didn't have How important? **0** _ **1** _ **2** _ **3** _

_____
_____
_____

Other: How important? **0** _ **1** _ **2** _ **3** _

_____
_____
_____

How Substance Use Prevents Healing From PTSD

There is no doubt that you want to heal from PTSD. No one wants to live with the suffering of that. But are you aware of how your substance use is preventing you from healing from PTSD? The following list may help. Check off any that feel true for you.

USING SUBSTANCES ...

○ Makes PTSD symptoms worse. Substances can make you feel more depressed, more suicidal, and less stable. Even if substance use appears to "solve" some PTSD symptoms for a short while (such as getting to sleep or numbing out for a few hours), in the long run it never solves them.

○ Prevents you from knowing yourself. With substances, you get lost. To heal from PTSD, you need to become more and more aware of who you really are—without substances.

○ Does not get your needs met. You may be using substances to feel loved, to accept yourself, to feel less pain, or to feel nurtured. However, substances cannot give you these. Developing safe coping methods to meet these very important needs is an essential part of healing.

○ Stalls your emotional development. Although you may be an adult in terms of your age, emotionally you may have become "stuck" somewhere earlier in your development, due to PTSD, substance use or both. If you give up substances, you can keep growing emotionally.

○ Isolates you. You cannot have good relationships when high. One of the main features of PTSD is isolation: keeping secrets, having to lie about what happened, feeling alone. Substance use perpetuates that aloneness.

○ Keeps you from coping with feelings. It can feel unbearable to face the feelings associated with PTSD, and it may be tempting to use substances to "self-medicate." But healing means learning to be comfortable with strong feelings through safe coping. Healing is possible if you can give up substances that are getting in the way.

○ Takes away your control. One of the most difficult aspects of PTSD is that you had no control over the trauma. The very nature of substance use is that it also takes away your control – it runs your life. Take back your power by giving up substances!

○ Makes you hate yourself. You can't feel good about yourself when you are being controlled by a substance. With PTSD, you may already dislike yourself; substance use just adds to that.

○ Is a way of neglecting yourself. Using substances impairs your health, your mind, your relationships, your self-worth, and your spirituality. If you suffered childhood neglect or abuse, substance use may be a repetition of that pattern, except that now you are doing it to yourself.

Healing from PTSD requires all of your care and attention. Substance use keeps you stuck.

Safety Plan For A Woman Using Substances

If drug or alcohol use occurs alongside violence in my relationship with my partner, I can enhance my safety by doing some or all of the following:

I will try to remember that:
- It is easier to keep safe when I am not using substances.
- Alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services.
- I find it hard to ask for help when I am using or drinking.

Things I can do:

I can call _____ for support when I feel like drinking or using to cope.

The following people/places/things can be unsafe for me: _____
_____
_____
_____

My warning signs that I am getting stressed and craving substances are: _____
_____
_____
_____

and this is what I will do in these situations to try to keep myself from drinking/using and to try to keep myself safe: _____
_____
_____
_____

If I am going to use, I can do so in a safe place and with people who understand the risks of violence and are committed to my safety. I can: _____
_____
_____
_____

I can also:

_____

_____

_____

_____

If my partner is using/drinking I can:

_____

_____

_____

_____

I might also:

_____

_____

_____

_____

To safeguard my children I might:

_____

_____

_____

_____

Resources Section

Telephone Help And Information Lines

Mental Health

Local Crisis Line
Your local crisis line number is listed on the first page of your White Pages, or call 1-800-SUICIDE (1-800-784-2433). Available 24 hours a day, 7 days a week, to connect to a BC crisis line without a busy or wait signal.

Crisis Intervention and Suicide Prevention Centre of BC
24 hours
1-800-784-2433
TTY: 1-866-872-0133

Centre for Suicide Prevention
Has a listing of crisis centres and on-line counselling services across Canada http://www.suicideinfo.ca.

BC Mental Health Information Line
Information about mental health and mental health services: 1-800-661-2121 or 604-669-7600.
See www.heretohelp.bc.ca/connectmeto/infoline.shtml.

Substance Use

BC's Alcohol And Drug Information Service
1-800-663-1441
TTY: 604-875-0885
This is an information and referral service available 24 hours a day, 7 days a week.

Vancouver Coastal Health
Information is available from the Addiction Services Information at Vancouver Coastal Health, ACCESS 1: the toll free detox number is 1-866-658-1221.

Fir Square
For pregnant substance-using women, Fir Square Combined Care Unit at BC Women's Hospital and Health Centre. Women may self-refer at 604-875-2229 (ask for the "charge nurse").

BC Nurseline Health Information And Advice
Toll-free telephone line staffed by registered nurses 24 hours a day, 7 days a week. Translation services are available in 130 languages. A pharmacist is also available through this line.
1-866-215-4700 • TTY: 1-866-889-4700

Poison Control Centre
1-800-567-8911
24-hour emergency line. For information on medications and drugs; particularly helpful around overdoses.

Support Groups

SHRA
The Self-Help Resource Association of BC publishes a directory of support groups in the Lower Mainland for a number of concerns including mental health: 604-733-6186, www.selfhelpresource.bc.ca.

Red Book
The Red Book of Community Social Services (for the Lower Mainland only) offers a similar online listing (look up support groups in the subject listing): www.vcn.bc.ca/isv/redbook.htm.

Legal Resources

Community Legal Assistance Society (CLAS)
Litigates test cases and seeks reform laws in all areas of law relating to economically, socially, physically and mentally disadvantaged people: 604-685-3425, www2.povnet.org/clas.

Mental Health Law Program (part of CLAS)
Provides free legal representation of patients at review panels under the Mental Health Act and Review Boards under the Criminal Code: 604-685-3425.

Community Advocate Support Line (CASL)
CASL is a direct phone service operated by the Legal Services Society as an adjunct to LawLINE. LawLINE lawyer can provide brief legal advice, information, and coaching to support advocates' work on behalf of clients.
1-877-601-6066 (advocates only; please do not give number to general public)

Selected Websites
This is just a sampling of the many websites with information on trauma, substance use and mental health

Mental Health

American Self Harm Information Clearinghouse
www.selfinjury.org

Anxiety Disorders Association of BC
www.anxietybc.com

BC Mental Health Guide
www.helpguide.org

BC Schizophrenia Society
www.bcss.org

Canadian Association for Suicide Prevention
www.suicideprevention.ca

Centre for Suicide Prevention
www.suicideinfo.ca

Canadian Traumatic Stress Network
www.ctsn-rcst.ca

Information on Shock Therapy
www.ect.org

Mental Health Consumer Net Connections
www.mentalhealthconsumer.net/index-links.html

Mood Disorders Society of Canada
www.mooddisorderscanada.ca/social/senate/index.htm

Postpartum Support International
http://www.postpartum.net

Project Resilience
www.projectresilience.com

Resiliency in Action
www.resiliency.com

Selfharm.net
www.selfharm.net

Sidran Institute: Traumatic Stress Education and Advocacy
www.sidran.org

Visions Journal (published by BC Partners for Mental Health and Addictions Information) http://www.heretohelp.bc.ca/publications/

Substance Use

Alberta Alcohol and Drug Abuse Commission.
www.aadac.com

Canadian Centre on Substance Abuse
www.ccsa.ca

Centre for Addiction and Mental Health
www.camh.net

Centre for Addictions Research of BC
www.carbc.ca

FASD Connections
www.fasdconnections.ca

Fetal Alcohol Syndrome Consultation, Education and Training Services, Inc.
www.fascets.org

Healthy Choices in Pregnancy (alcohol and pregnancy)
http://www.hcip-bc.org

Our Bodies, Our Selves Health Resource Centre http://www.ourbodiesourselves.org/book/chapter.asp?id=3

Prevention Source BC
www.preventionsource.org

The Prima Project (Pregnancy Related Issues in the Management of Addictions)
www.addictionpregnancy.ca/home.html

Psychological Trauma and Substance Abuse in Women (website of Barbara Hilliard)
www.home.earthlink.net/~bhilliard

Substance Information Link (Centre for Addictions Research of BC)
www.silink.ca

Watari (drug services for youth)
www.watari.org

Safety Planning/trauma Assessment

Many Faces of Violence: Safety Plan
http://mfv.ca

Seeking Safety Model
www.seekingsafety.org

Trauma Center (website of Dr Bessel van der Kolk)
www.traumacenter.org

Articles

We have made an effort to cut down on repetition: please check the resource sections at the end of each chapter for additional resources not listed here. As well, we have tried not to repeat resources under different subheads below. So an article might fit into a number of categories, but we have only listed it once.

Many of these resources are available online. If any of the links below do not work, try going to the home page of the organization and searching for the document; its location may have changed. If that does not work, try finding the resource using Google or another search engine.

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