Women and Safehouses in Canada

Advocates for women's mental health have responded to the Final Report of the Standing Senate Committee (May 2006) by asking "where are the women?" A pattern of omission exists, which goes back over the years. We note that the 1987 CMHA report recommendations were never implemented by the various levels of government, by clinicians' training programs or even by the CMHA itself. Landmark federal studies, like the Romanow and Kirby Reports, have remained gender-blind in their analysis. This trend has continued through the Senate Committee's first three volumes on Mental Health, Mental Illness and Addiction. They do not systematically and comprehensively address mental health issues as they pertain to women, or consult widely with experts in the women's health and mental health fields. This omission warrants serious consideration, given the well-documented evidence indicating significant gender differences in the prevalence and manifestation of certain mental illnesses, in how women and men use mental health services, and in the specific needs and concerns of women with substance use problems or co-occurring disorders.[1]

Currently in Canada, mental health and addictions systems are being merged, with the medicalized approach of the mental health system dominating, at the expense of multifaceted, comprehensive and women-centered addictions and trauma informed approaches. The challenge in merging addictions and mental health systems is to at the same time improve them by making them more accessible, comprehensive, integrated and continuous.[2]

Why do women need safe houses? Many women's experiences within the psychiatric system are as bad, or worse than, the problems that caused them to become psychiatrized in the first place.

Psychiatrized women need to be able to take control of their own lives, to learn to trust themselves and other people again, to stop seeing themselves as helpless victims – as sick, defective, second class citizens or as mental patients. Women need to be safe, but just as importantly, women need to be free. The single alternative resource most urgently needed are safe houses where women can get through crisis in constructive ways, or prevent crisis by finding real help before things get too serious. Women need a refuge, a place where they can be with peers who will respect and care about them. Above all, women need places where they can choose what kind of help they want, and that choice will determine what they do and what happens to them.[3]

Again and again, focus group participants have stated that they needed a place to be safe from physical, sexual, emotional and mental violence. Many women felt that they were at the mercy of doctors, partners, relatives, and/or mental health workers and needed respite from these people's demands and impositions. All of the participants felt that they had been harmed by the psychiatric system, and never wanted that to happen to them again. Participants were in agreement that the psychiatric system failed to acknowledge the abuse

suffered by women, and did not respect the emotions that resulted from this abuse. Many focus group participants agreed that their legitimate distress had been medicalized by psychiatrists and then turned into a "disease". Instead of being properly heard, with empathy and understanding, these women were labelled and drugged. Having access to a safe house is very helpful for women who decide that they really want to come off the medications.[4]

Psychiatric diagnosis is not an empirical science. However, most patients are not fully informed of the limitations of the diagnostic labels that are usually the basis for therapists' treatment recommendations, and it is extremely rare that they are informed of any of the negative legal, economic, social, employment, emotional, or other negative consequences that can result from simply receiving a psychiatric label. For women, such diagnoses can also obfuscate the effects of larger, chronic social inequities like poverty and violence, instead mistakenly identifying women's bodies as the problem. Pharmaceutical drugs are the physiologically based treatment prescribed far more often than any other, and they are extremely likely to be prescribed when formal diagnoses are given. In many cases, however, patients are not made aware of the side effects of such medication, nor are they offered alternative treatment options which are often less invasive and more effective. [5]

Analysis

A successful safe house that has been operating for over ten years is the Berlin Runaway House. The majority of those who seek advice and support in the Runaway House have long histories of psychiatric treatment. On average, psychiatry has largely determined the residents' lives for more than ten years. Most have been institutionalized several times, forcibly treated, and heavily drugged. They have been labelled with all kinds of psychiatric diagnoses during their stays in psychiatric institutions. These diagnostic labels are completely irrelevant in the Runaway House.[6]

Statistically, it is evident that the longer clients stay in the Runaway House, the more likely it is that they move into their own apartments or into a considerably less intensive form of supported accommodation than they were in before. 20 % moved into their own apartments, 25 % moved into other institutions, such as sheltered accommodation, supported living, or women's places. 17 % went to stay with friends or their families. Only 13 % went into a psychiatric hospital. 7 percent left to live in the street or in shelters for homeless people, and the whereabouts of the rest are unknown.[7]

Compared to the cost of keeping people on psychiatric wards, the cost of operating the Runaway house is extraordinarily cheap, i.e. 300 – 700DM per day versus 200DM per day.[8]

Another project, known as Soteria House, is also significant regarding positive outcomes. Looking at the six-week outcome, in terms of psychopathology, subjects in two groups improved significantly and comparably, despite the fact that Soteria subjects did not use neuroleptic medications. In regards to community adjustment, two psychopathology, three treatment, and seven psychosocial variables were analyzed. At two years post-admission,

Soteria-treated subjects from the 1971-76 cohorts were working at significantly higher occupational levels, more often living independently or with peers, and had fewer readmissions. 57 % had never received a single dose of neuroleptic medication. In the first cohort, despite the large differences in lengths of stay (about one versus five months), the cost of the first six months of care for both groups was about $4,000.[9] (in 1975 US dollars).

With the second group, from 1976-82, admission, six-week, and milieu assessments almost exactly replicated the findings regarding the initial cohort. At two years post-admission, the second cohort experimental subjects, as compared with controls, had become more independent in their living arrangements. Longer term outcomes (two years) for the experimental groups were, as good, or better than those of the hospital treated control subjects.[10]

While there is a growing recognition of the effect of violence and abuse on the mental health of women and children, more work remains to be done on the gender-related aspects of the determinants of health. Violence and trauma including childhood abuse, sexual abuse, and intimate partner violence are common in women. Approximately half of Canadian women have survived at least one incident of sexual or physical violence, and four out of five victims of family-related sexual assaults (79%) are girls.[11] Substance use and mental health problems often co-occur among women who are survivors of violence, trauma, and abuse – often in complex, indirect, mutually reinforcing ways.[12] The overlap is not restricted to a small group of women. As many as two-thirds of women with substance use problems report a concurrent mental health problem, often related to their experiences of surviving physical and sexual abuse as children or adults.[13,14,15]

Regarding spousal violence, in 2004 there were nearly 28,000 incidents reported to police, where 84 percent of cases involved female victims and 16 percent involved male victims. Current knowledge indicates that spousal violence frequently involves multiple violent incidents. This pattern of behaviour of repeated violence increases the potential for life-threatening harm.[16] We note that victims are just as likely to be injured from a single incident of spousal abuse (53%) as they are from repeated (51%) or chronic (52%) abuse.[17]

Between 1974 and 2004, the rate of spousal homicide against females has been 3 to 5 times higher than the rate of male spousal homicide. Rates of spousal homicide are highest for young adults compared to older age groups, especially for female victims. Between 1995 and 2004, younger women (aged 15 to 24) were killed at a rate that is 3 times higher than the overall rate of female victims of spousal homicide.[18]

Recommendations

While a commission is a worthy mechanism to help build an action plan and accountability mechanisms for improving care, this should not be used to avoid taking action now. The proposed Canadian Mental Health Commission should adopt a commitment to a gender-based analysis from its inception. In order to represent and respond to its constituency, at least half of the Commission's seats should be reserved for women, including women's health advocates from diverse backgrounds. The proposed Knowledge Exchange Centre (KEC) should establish a centre on women immediately and work in close collaboration with existing researchers, organizations and programs in the field.[19]

A comprehensive approach to addressing women's mental health, mental illness and addictions must range from continued efforts to achieve equality between men and women and among women, to mental health promotion, illness prevention, community-based care and tertiary care, when necessary. While the Commission and its proposed activities may perform an important role as a national focal point for anti-stigma campaigning and information dissemination, there is **an urgent need for new and separate funding for mental health promotion and care now.**[20]

The current service delivery system must be restructured and expanded to accommodate women's diverse and socially embedded mental health needs. To this end, the following[21] measures should be taken:

- Increase affordable and safe housing for women. Build supports for substance use/addictions issues around a framework of women-centered care. This includes the need for more women-only facilities as well as gender-specific supports for women and men around trauma issues.

- Have trained staff, whether paid or unpaid, to be trained in the following areas:[22]

    * empathy and active listening skills
    * making referrals, help with filling out forms
    * non-judgmental and culturally sensitive
    * crisis intervention
    * warning signs
    * de-escalation techniques
    * dealing with the effects of trauma and sexual abuse, including childhood sexual abuse
    * dealing with bad reactions from drugs, including street drugs
    * how to come off medications

- Increase support and funding for consumer initiatives led by women consumers;

- Women with mental health and addiction concerns must be included in the development, management and evaluation of health services that are provided to them;

- Increase funding for multi-disciplinary, comprehensive community-based mental health services that include, for example, accredited mental health workers, social workers, nurses, health educators, occupational therapists, physiotherapists, etc.

- Increase training for gender-sensitive and women-centered mental health care for health care providers and managers;

- Increase funding for women's anti-violence work and educational campaigns;

- Institute broad-based policies to reduce the hypersexualization of girls and young women;

- Institute media literacy programs for young women and regulate the portrayal of female bodies in advertising,

- Improve legislation regarding pay equity;

- Improve pension arrangements that account for women's particular work experiences;

- Improve development of and access to alternative models of care, such as feminist therapies and other effective interventions;

- In volume 3 of the Interim Report, a question was raised about merging mental health and addictions and substance use services. There are some sound arguments and appropriate contexts for the aggregation of mental health, mental illness and addictions in analysis and intervention. However, given a legacy of the criminalization of addictions, and of the overmedicalization of women's distress, for example, such aggregation must be undertaken with extreme caution and vigilance.

- The federal government should create a Mental Health Service Innovation Fund, modeled on the Health Transition Fund, to stimulate the development of new, innovative and alternative community-based services for treatment and promotion of mental health, substance use and addictions that could be accessed by community groups.

- Fund research that enhances understanding of sex and gender specific dimensions of mental health/illness and addictions. Research is urgently needed regarding dynamic interactions between sex and gender and other determinants of health which inform the etymology, diagnosis, trajectory, treatment, and consequences (including

treatment-related consequences) of mental health/illness and/or addictions for women and men.

- Create mechanisms and organizational support through which research results can be accessed by women and mental health consumers to enhance their input into policy and decision-making.

- Support the funding of research through both Health Canada and CIHR into **non-pharmacologic** ways of treating mental health concerns, and ensure that the results of these trials are made publicly known.

- Eliminate direct-to-consumer advertising of prescription drugs.

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