Hearing Women's Voices

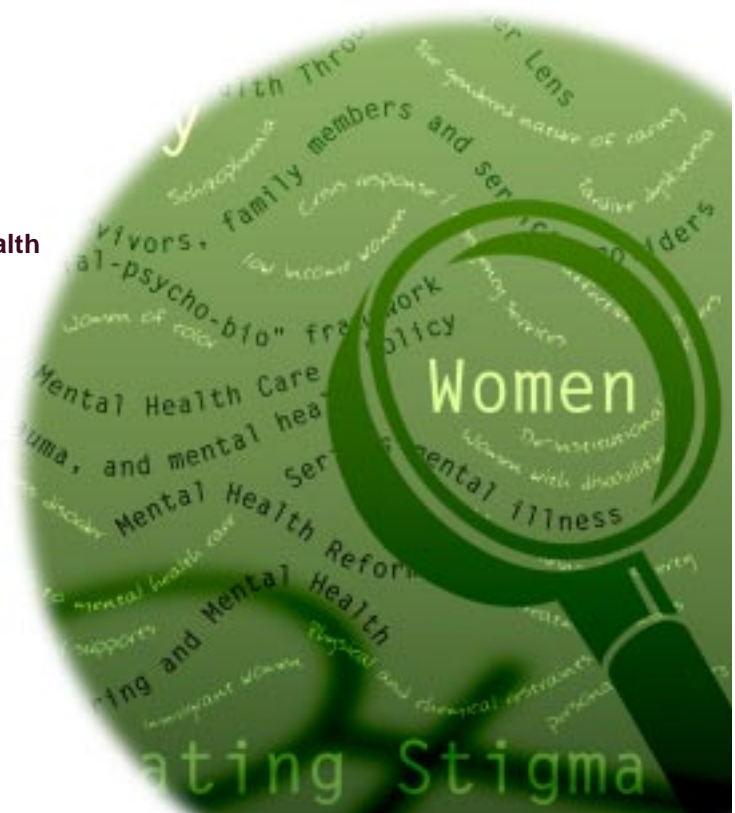## Mental Health Care for Women

**By Marina Morrow
with Monika Chappell**

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

BC Ministry of Health

**Minister's Advisory
Council on Women's Health**

**BC Ministry of
Women's Equality**

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Acknowledgments

Finally, we would like to thank all of the individuals who gave their time to meet with us and we especially acknowledge those women who generously shared their personal experiences with us. Their work and lives are the foundation of this report.
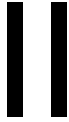
II

Executive Summary

Women's mental health cannot be understood in isolation from the social conditions of our lives. These conditions are characterized by social inequities (e.g., sexism, racism, ageism, heterosexism, ableism) which influence the type of mental health problems women develop and impact on how those problems are understood and treated by health professionals and by society.

The differences between men's and women's experiences of mental health concerns, and in particular, the links between social conditions and women's mental health, have been well documented.[1] There is also an emerging body of literature on the ways in which chronic mental health problems develop differently in women and men (i.e., clinical differences) as well as research on the connections between women's mental health status, biology and women's life cycle stages (e.g., Seeman, 1981 & 1983; Seeman & Lang, 1990). The recognition that mental health is in part socially determined has led to commitments in some national and provincial mental health policy frameworks to shift from a bio-medical understanding of mental health towards a "bio-psycho-social" understanding.[2] Additionally, some jurisdictions have singled women out as a group that needs particular attention (e.g., BC Mental Health Plan, pg. 27).

Nevertheless, this shift has yet to be fully realized in mental health policy development and in the delivery of mental health services. Interviews and focus groups with women who have chronic and persistent mental health problems,[3] service providers, women family members and caregivers in British Columbia reveal that a gendered analysis of policy and service delivery has not been systematically and consistently integrated into existing policy and service delivery structures. Services which recognize the specific needs of women are often dependent on the will of individual service providers, and women's mental

We advocate both change from within and a transformative vision of what mental health care can be.

health planning is ad hoc and unsystematic. The implications of this lack of a gendered analysis are profound in terms of consumer satisfaction, clinical outcomes and service utilization.

Many barriers exist with respect to advancing a women's mental health agenda. These include resistance to a gendered understanding of mental health on the part of many policy makers and the rearrangement of the fiscal and service delivery structures of health care. We respond to the latter by critically examining the impact of mental health reform on women and by offering analyses and guidance regarding the implementation of the BC Mental Health Plan.

We advocate both change from within and a transformative vision of what mental health care can be. We recommend reforms that will help the current system better respond to the needs and concerns of women, and at the same time we advocate a paradigm shift that acknowledges the inadequacy of bio-medical explanations for understanding women's mental health.

In our work we attempt to advance the understanding of women's mental health concerns, and to represent some of the debates that are currently taking place in the mental health reform process. Our research should not be viewed as comprehensive or the final word, but rather as an invitation to continue struggling with the complexities of the issues we present.
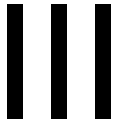
III

The strong leader-ship of women consumer survivors on the Project Advisory Group[5] facilitated the development of a methodology that ensured that women who have had personal experience within the mental health system[6] would be central to the process.

Context

This project emerged from discussions that took place in the Women and Mental Health Reform Discussion Group at the BC Centre of Excellence for Women's Health.[4] The impetus for the discussions was the release of the 1998 BC Mental Health Plan. While members of the Discussion Group appreciated the Plan's consideration of the specific needs and concerns of women with chronic and persistent mental health problems, they were concerned that no mechanisms existed to ensure that the plan's goals would be comprehensively carried out. The current project was designed to assist in the implementation of the Mental Health Plan as well as to provide a broader understanding of mental health reform and its impact on women.

All phases of this project were carried out under the guidance of a 15-member Project Advisory Group that has representation from consumer survivors, service providers, mental health planners, researchers and policy makers. The project was conducted with the support of the BC Ministry of Health, the BC Ministry of Women's Equality, the Minister's Advisory Council on Women's Health, and the BC Centre of Excellence for Women's Health.

At the outset, the Advisory Group felt it was essential to canvass the views of a wide-range of stakeholders. Plans were developed to conduct interviews and focus groups with women who have chronic and persistent mental health problems, women family members, caregivers, mental health care workers, mental health planners, researchers and policy makers. The strong leadership of women consumer survivors on the Project Advisory Group[5] facilitated the development of a methodology that ensured that women who have had personal experience within the mental health system[6] would be central to the process.

A feminist participatory action framework that was consumer-centred evolved through a collaborative process between the researchers and the Project Advisory Group.[7] The experiences of a wide range of mental health constituents were used as an axis point from which to understand mental health reform and the larger structures governing mental health. This process ensured that the framework that emerged grew out of the context of actual experience with the mental health care system as well as out of related literatures and mental health care policies. The research was therefore "grounded" (Glaser & Strauss, 1967; Creswell, 1998) in that the researchers remained open throughout the fieldwork process to emerging issues and themes, without fixing rigidly on categories or frameworks prior to conducting the fieldwork. A triangulated method was used (Lincoln & Guba, 1985; Mathison, 1988) which involved looking at several data sources (in this case, focus groups, key informant interviews and the literature and policy review)

simultaneously to better understand the area of study.

The study involved:

· A critical analysis of literature to determine current knowledge and practice with respect to women and mental health.[8]

· A critical analysis of existing mental health policy and legislation (e.g., BC Mental Health Plan and the BC **Mental Health Act**) in order to identify whether and how they integrate the particular concerns of women consumers. Additionally, "gender lens" analysis tools[9] were examined to determine their usefulness as tools for examining mental health policy.

· Focus groups and key informant interviews. Focus groups were used to canvass the views of women consumers and a broad range of mental health service providers and women family members. Key informant interviews allowed the researchers the opportunity to do in-depth interviews with consumer advocates, anti-psychiatry activists, mental health planners, policy makers and other key people involved in the mental health system.

Focus Groups

Twenty focus groups were conducted in eight different communities. Of these groups 12 were conducted with consumers and the remaining eight with service providers.[10] Women family members and caregivers were represented in each community and, depending on the judgement of the community developer, attended either the service provider group or the consumer group.

Care was taken to represent the concerns of women consumers who differ widely in their needs according to their particular social positioning (i.e., race, culture, ethnicity, class, ability, sexual orientation, age) and life experiences;[11] however, the primary focus was on women with serious mental health challenges.[12] For a more detailed profile of the research participants see Appendix A.

Key Informant Interviews

Individuals were chosen to represent particular constituencies in the mental health system (e.g., family advocates, policy makers), to represent certain innovative practices (e.g., women consumers running support groups for women of colour and immigrant women, women involved in providing transitional housing for women with mental health issues), and to represent those in opposition to the practices generally found in the mental health system (e.g., anti-psychiatry activists). Other informants were chosen because of their overall knowledge and expertise in policy making and mental health planning either locally or nationally. Twenty key informant interviews took place.

The Research Sites

Research sites were chosen for geographic representation but also with particular communities in mind. That is, care was taken to ensure rural and isolated northern perspectives as well as the perspectives of Aboriginal women.[13]

Analysis of Material

The focus groups and key informant interviews were audiotaped. Detailed notes were taken by both researchers who attended each focus group. Field notes were taken after each session as

a way of reflecting on the process and the emerging themes. Thematic analysis (Marshal & Rossman, 1995) was used to analyze the data following a framework outlined by Kate McKenna and Sandra Kirby (1989).

IV

Looking Through a Gender Lens

Looking at mental health through a gender lens reveals that both physiological and social differences between women and men have an impact on mental health. Research on the connections between mental health status, biology and women's life cycle changes (e.g., menarche and menopause) and on clinical differences between women and men are providing important contributions to our understanding of gender and mental health. In this section we have chosen to focus more closely on the social determinants of mental health which have most often been neglected.

A. The Social Determinants of Mental Health

Men and women experience mental health concerns in different ways. As Pat Fisher indicates:

"Issues of entitlement, power, differing socialization norms, experiences of previous exploitation and abuse, beliefs about male privilege, etc. all serve to influence the experience and course of women's mental illness (1998:7)."

Caregiving and family responsibilities, economic insecurity and experiences of violence and abuse are common for women. These and other social conditions influence the ways in which helping professionals respond to women, the psychiatric diagnoses women receive, and women's ability to access and beneficially utilize mental health services.

For example, studies have found that women use mental health outpatient services more often than men (Rhodes & Goering, 1994). Usage patterns also differ among diverse groups of women for example, some groups of women (i.e., Aboriginal women, immigrant women) may not have sufficient access to mental

Key here is the recognition that social support and access to financial resources are determining factors in the type of mental health care a woman can access.

Diagnoses

Women are more often diagnosed with affective disorders, personality disorders and post-traumatic stress disorder (Canadian Mental Health Association, 1987; Vancouver/Richmond Health Board, Women's Health Planning Project, 1999)

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health services (Boyer, Ku & Shakir, 1997).

Further, studies suggest that women are more often diagnosed with affective responses,[14] personality responses and post-traumatic stress response (Canadian Mental Health Association, 1987; Peters, 1999). A number of American epidemiological studies suggest that women outnumber men on all major psychiatric diagnoses except antisocial personality response and alcohol abuse (Mowbray, Herman and Hazel, 1992; Eaton & Kessler, 1985). Differences in the ways women from diverse ethno-cultural backgrounds are diagnosed have also been found (Rodriguez, 1993). These diagnostic variances cannot be explained solely by physiological differences between women and men. In fact, research has shown that diagnostic tools and diagnostic processes reflect the systemic biases (e.g., sexism, racism, classism, heterosexism, ableism and ageism) found in society more generally (Caplan, 1985 & 1995). The diagnosis a woman receives can directly determine what forms of treat-

ment she is eligible for within the mental health system, and will greatly impact on the type and extent of care she receives.

Historically, mental illness has been understood using a predominantly bio-medical model. The new BC Mental Health Plan recognizes that this model is inadequate for understanding and responding to mental illness and recommends a "bio-psycho-social" model (p. 17). Our research suggests that women's experiences of mental illness cannot be fully understood without reference to the social environment in which they live. This environment is characterized by social inequities (e.g., sexism, racism, ageism, heterosexism, ableism). For many women social conditions of inequity, in particular experiences of violence, precipitated their entry into the mental health system. In other instances social conditions, especially poverty, created barriers to women's recovery from mental health challenges.

Key here is the recognition that social support and access to financial resources are determining factors in the type of mental health care a woman can access.

In each community, we heard about how lack of resources for women made their lives and those of their children more difficult.

For example, if a woman is dependent on government-sponsored services, it is more likely that her mental condition will be closely monitored and that treatment choices will be limited. On the other hand, if a woman has financial resources, it is more likely that she will be able to access private services which circumvent scrutiny from government agencies and often the labeling process that occurs upon entering the mental health system.

1. Poverty

Poverty disproportionately impacts on women (The National Action Committee on the Status of Women, 1997) and therefore is a major contributing factor to women's mental and physical well-being. For a number of different reasons poverty has a dramatic impact on women's abilities to become well and maintain that wellness:

· Poverty impacts on women's abilities to access services, that is, women without financial resources have fewer treatment choices.

· Poverty is the major contributing factor to homelessness

· Poverty makes women economically dependent and therefore more likely to stay in abusive relationships. Combined with isolation, this can compound women's mental health problems

· The poverty of women often means the poverty of their children.

In each community, we heard about how lack of resources for women made their lives and those of their children more difficult. The levels of social assistance mean that women are only able to access publicly funded services, making it almost impossible for women living in poverty to access any kind of counselling or alternative treatments. The combined impact of an unresponsive service system and inadequate income support often results in women losing custody of their children. This has a dramatic impact on the mental health of both women and their children.

The concerns of young, single mothers were particularly acute. Often because their education

had been interrupted, these young women had the least likelihood of being able to find stable employment.

When women attempt to seek a level of assistance that recognizes the needs of people with mental health problems (i.e., provincial disability benefits) they face myriad obstacles. Provincial ministries continue to use physical disability as the primary indicator for social assistance needs (BC Coalition of People with Disabilities, 1998).

Massive cuts to social services in recent years are having dire effects on individuals living in poverty. These conditions are magnified for women with mental health challenges who often cannot navigate through the system or advocate on behalf of themselves or their children. Women's ability to participate in their communities is diminished by poverty, and poverty further isolates and stigmatizes women.

2. Housing

One of the most pressing concerns for women in or leaving the mental health system is access to safe, affordable housing. Currently, there is an acute housing crisis in many regions of British Columbia. The full continuum of housing supports includes: short term shelters or transition houses, supported housing, family care homes, housing co-operatives and staffed residential facilities.

Many Vancouver women are forced to live fearfully in sub-standard apartment hotels in the downtown core. In rural and remote areas there are sometimes no supported independent living spaces, and/or limited access to residential care facilities.

In our focus groups the issue of safety in housing came up repeatedly. Women spoke about how residential care facilities with predominately male occupants were uncomfortable for them and about how there were virtually no women-only housing complexes available.

Women who have been forced out of their homes because of the violence of a male partner often cannot access transition shelters, whose mandates may restrict them from housing women with mental health or substance

In rural and remote areas there are sometimes no supported independent living spaces, and/or limited access to residential care facilities.

Mental Health Care Utilization

Although the data is mixed on this issue, women and men appear to have different mental health care utilization patterns. For example, women tend to use outpatient services more than men (Rhodes & Goering, 1994).

Stigma affects both men and women but there are specific effects on women.

Development Differences

Studies suggest that the development of serious mental illnesses in women and men may differ. For example, women are more prone to changes in mental health status as a direct consequence of their biology and life cycle changes (Women and Mental Health Working Group, 1996).

use problems, due to concerns about disruptive behaviour and the safety of other residents. Some exceptions exist. For example, Peggy's Place in Vancouver, and Savard's House in Toronto, both of which shelter psychiatrized women.

Women throughout the study identified the need for accessible, safe, affordable housing for themselves and their children. The provincial housing partnership recommended by the BC Mental Health Plan[15] is a good step but requires further commitment from both the provincial and federal government. From the federal end, the Canadian Mortgage and Housing Corporation should return to the provision of social housing to ensure that the needs of all individuals are met. In accordance with recommendations made at the Mental Illness and Pathways into Homelessness conference in Toronto (January, 1998) a national policy pertaining to homelessness should be developed which recognizes homelessness as a determinant of physical and mental health.

3. Stigma

In one of our focus groups a woman who had been diagnosed with dissociative identity response spoke about how this diagnosis had affected her both within and outside of the mental health system. While hospitalized she was ostracized by nurses and other health care professionals who were afraid of her. The stigma for this woman ran so deep that after revealing her diagnosis in the focus group during a discussion about labelling, she broke down in tears and offered to leave the group if other people were afraid of her.

Mental illness is highly stigmatized in our society. Stigma affects both men and women but there are specific effects on women. Historically, mental illness was linked to women's reproductive organs and women were therefore seen as more vulnerable to mental deterioration. Rigid societal attitudes about appropriate female behaviour mean that non-conforming women are often labelled as mentally ill. Current societal and individual responses to women displaying behaviours which are categorized

A gender lens which recognizes the social determinants of *mental* health needs to be applied systematically to mental health policies and planning.

as "mental illness" include fear, misunderstanding and punitive or paternalistic measures. Women experiencing mental health problems are not commonly seen as credible persons who deserve respectful and caring responses. Myths about the dangerousness of people diagnosed with mental illnesses exacerbate this stigma.[16]

Stigma extends into the mental health system itself, where certain mental illness diagnoses are viewed as less desirable than others. Some of the most stigmatized diagnoses are those most often given to women, for example, borderline personality response and dissociative identity response.

Mental illness diagnoses commonly serve to limit individual's active participation in the community. For example, women in our focus groups indicated that diagnostic labels had been used in custody and access disputes to discredit them as mothers.

Anti-stigma education modeled after anti-oppression work is needed for health care professionals and the public.

Early education would help young people to grow up with less prejudice against people with mental health challenges. Positive and realistic representations of the contributions and recovery of people with mental health problems offers an alternative to demeaning stereotypes. The increased participation of women consumers in the design of policy and service delivery would help to reduce stereotypes and myths about mental health challenges.

Recommendations

· A "social-psycho-bio" framework which places the first emphasis on the social determinants of mental health should be adopted by all provincial jurisdictions.

Already existing frameworks like the 1993 Canadian Mental Health Association's **A New Framework for Support for People with Serious Mental Health Problems** and other Mental Health Promotion frameworks could be useful in this regard should they incorporate a gender analysis. Mental Health Promotion is defined by the Centre for Health Promotion as:

"The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for equity, social justice, interconnections and personal dignity (Willinsky & Pape, 1997:3)."

Mental Health Promotion reflects a paradigm shift in mental health, away from a focus on illness to a focus on wellness and how to maintain and foster mental health. The focus in Mental Health Promotion on the individual's social environment and on equity and social justice is consistent with the social determinants approach to mental health we are recommending.

· Gender mainstreaming and the development of a women's mental health agenda.

The social determinants of physical health are increasingly being recognized at a policy-making and health-planning level (e.g., BC Ministry of Health and Ministry Responsible for Seniors, 1995 & 1998).

Additionally, gender lens tools which are used to analyze the impact of policies on women are increasingly being adopted by policy makers throughout Canada.

A gender lens which recognizes the social determinants of mental health needs to be applied systematically to mental health policies and planning. Gender lens tools are limited, however, if they are not accompanied by education and a participatory policy structure[17] which allows formalized interactions among different mental health constituents. The use of a special lens for policy analysis has been described as restricting the analysis to the content or "actual ingredients" of a policy: its goals, values and benefits (Wharf, 1998: 52). These approaches give limited attention to how policies actually emerge and why they have developed the way they have (Wharf, 1998). A process approach which combines gender lens tools with education and participatory policy making is therefore necessary.

Through the use of a gender lens, issues specific to the experiences of women and men emerge. We recommend that these issues be documented and those that pertain to women be developed

into a women's mental health agenda. This agenda would prioritize the full range of diverse women's mental health concerns so that they can be addressed systematically.

Fosters peer support and self help

Bases care on women-centred principles and values

Focuses on healing and wellness

Addresses physical and sexual abuse in women's lives

Gives all women equal access to mental health care

Women-Centred Mental Health Care

Responds to women's needs across the life span

Gives women choices about mental health care

Recognizes that stigma has specific effects on women

Addresses the social determinants of mental health

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V

Women-Centred Mental Health Care

In this section we examine our research participants' specific concerns about mental health care. These concerns led us to think about how models of women-centred care based on a feminist ethic of caring (e.g., Taylor & Dower, 1997; DiQuinzo & Young, 1997) might be useful for the mental health system. In order to address these concerns we make specific recommendations which pertain to each care issue raised. These recommendations are meant to reflect the women-centred mental health care values and principles that we outline below.

The general principles of a women-centred care model include:[18]

· Recognition of women's diversity

· Recognition of women's self-determination and autonomy

· Recognition of women's strengths rather than a focus on negative stereotypes

· Recognition of the value of women and their lived experiences: being listened to and believed

· Recognition of the interconnections between physical, mental and spiritual health

· Recognition of the ways in which male physiology and behaviour have been used as the norm for understanding physical and mental health and how it is inappropriate to apply these understandings to women

· Provision of continuity of care

· Provision of options to utilize women-only services and to access women caregivers

· Recognition of women's roles as mothers and caregivers includ-

ing the provision of child care to allow women better access to a wider range of services.

We recommend the adoption of these principles in addition to the principles and values of women-centred mental health care that we present below. These principles and values have been derived through consultation with the diverse constituencies of women we spoke with.

A. The Principles and Values of Women-Centred Mental Health Care

· Recognition that the stigma surrounding mental illness has specific effects on women

· Recognition of the social determinants of mental health and their impact on women across the life span

· Recognition of the role of physical and sexual abuse in women's and girls' lives and how this impacts on mental health

· Recognition of how inequities that oppress women are reproduced in mental health care policy and service design and delivery

· Recognition that women must be actively involved in decision making around their treatment and must have a choice of treatments

· Recognition of the important role of self-help and peer support

· Recognition that women with mental illness diagnoses often do not have access to existing women-centred services

· A new language which articulates a shift in focus to wellness and the process of healing

· Equal access for all women to mental health care

· Recognition that women carry the burden of caregiving.

These principles should be used to guide the development of services and as the basis for service-provider education. For example, training on women's mental health challenges would be part of the curriculum for professionals and they would receive training updates yearly.[19] Women consumer survivors would help to develop, implement and monitor training.

In developing and implementing women-centred mental health care, the diversity of women must

These principles and values have been derived through consultation with the diverse constituencies of women we spoke with.

In any discussion of women-centred care it is critical to acknowledge that much of the caregiving of individuals with serious mental health challenges is carried out informally by family members who are most often women.

be recognized. Diversity among women means that not all women will experience mental health problems and the mental health system in the same way. Therefore, the particularities of women-centred approaches to mental health care in jurisdictions throughout Canada must be derived through consultation with diverse constituencies of women.

Although some of the women we spoke with had not found feminist service organizations helpful, women's use of feminist services which often stand outside of the traditional mental health system (e.g., transition houses, immigrant women's organizations, Elizabeth Fry Society, etc.), suggests that women are receiving mental health care from under-acknowledged sources. This pattern provides clues to what alternative support models might be useful for women. Services which recognize the social determinants of health, respect a woman's privacy, security and social support needs are necessary. Feminist organizations that are working from women-centred care models can

play a critical role in maintaining women's mental health and should be formally recognized. Alliances and "cautious"[20] partnerships need to be drawn between women consumer survivors, feminist front-line workers and mental health care providers.

B. The Gendered Nature of Caring

In any discussion of women-centred care it is critical to acknowledge that much of the caregiving of individuals with serious mental health challenges is carried out informally by family members who are most often women. This is particularly true as governments transfer responsibilities for health services to the community. Women often do this work in addition to all their other caregiving responsibilities (of children, male partners and ageing parents). As Evelyn Drescher, the author of a recent Canadian report on women's unpaid work indicates, "The reluctance to call 'caring' and 'caregiving' WORK is perhaps one of the most critical factors in reinforcing the notion that caregiving is a private rather than public or collective social

mple of how to apply the concept of gender mainstreaming to develop a Women-Centred Mental Health Agenda

Apply the Gender Lens to a specific service in the system of care
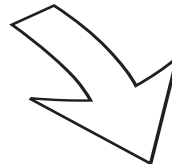
Housing

Family Support

Vocational/Educational

Consumer Initiatives
Peer Support

Inpatient/Outpatient Care

Act/Case Management

Emergency
Services
Crisis
Response
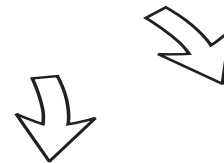
Recommendations:

Establish less intrusive alternatives to the use of restraints and isolation rooms

Implement policies that recognize that the use of restraints is innappropriate for trauma, sexual or physical abuse survivors

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responsibility" (1998:1). Further, she indicates:

"Without a framework for analysis informed by an understanding of unpaid work as a structural economic issue, 'caregiving' will continue to be relegated to 'soft' social policy discussions and welfare models. This will result in caregivers and their 'dependents' at best being 'taken care of' within public policy. Unpaid caregivers will remain 'dependents' or indeed, 'social parasites' rather than stakeholders who should have access to social resources as a right of their work. This argument bears directly on our understanding of the rights of citizenship, not to mention economic rights as human rights (Drescher, 1998:1)."

Drescher's analysis is highly relevant to our understanding of mental health reform and its particular economic impact on family members and caregivers. Specifically, it resonates with our participants' views that the government has a responsibility to caregivers and cannot simply download care responsibilities to family members without adequate financial resources and support.

In looking at mental health issues as they relate to family members and caregivers it is necessary to take into account their multi-faceted roles which include:

· Caregiving and support to one or more family members with mental health problems

· Advocacy in the mental health system for family members who have mental health challenges

· Acting as key "stakeholders" who can help formulate policy and service delivery responses in the mental health system

· Acting as consumers who have specific needs for support with respect to their caregiving roles.

⟶• Recommendation

A gender lens should be applied to any work related to understanding family support and caregiving. Applying a gender lens to these issues will allow for:

· A better understanding of who is providing care to individuals with mental health problems and under what conditions

· A better understanding of the physical, mental, financial and broader economic costs of caring

A gender lens

should be applied

to any work related

to understanding

family support

and caregiving.

· The development of recommendations that will best meet the needs of both male and female family members and caregivers.

C. Mental Health Care Concerns

The perspectives of service providers, women caregivers and consumers surrounding mental health care and the delivery of services sometimes overlapped and at other times differed. In some instances the views of one group directly conflicted with the views of another. Intra-group differences were also apparent.

There was agreement among all of our respondents that women's needs were not being met in the current system, especially those needs related to women's past experiences of violence and trauma and the need for women to have a wider range of support and treatment options. Service providers, women and caregivers gave many examples of how the care women receive is fragmented and does not address their needs as whole persons. Although some women had positive experiences, they were largely dependent on the knowledge and support of individual service providers. In other words, care that is sensitive to the concerns and life experiences of women is unsystematic and ad hoc.

D. Debates

A number of debates were apparent in our study. Acknowledging these debates and finding ways to work with these differences is a critical component of mental health reform. Here we draw out three of the debates that emerged in our study. How these debates are materialized will become apparent in our discussion of care concerns.

Debates about where resources in mental health should be focused

Service providers and consumer survivors expressed concerns that mental health reform, specifically the focus on "serious mental illness" in the BC Mental Health Plan, would mean that some groups of women would be unable to access services and support. Many of our respondents were concerned that restricting service mandates would mean that some women with serious mental health problems would "fall through the

cracks" and that their illness would be exacerbated as a result of not being able to access services. At issue here is how "seriously mentally ill"[21] is defined and who makes this determination. Our respondents were particularly concerned that commonly used diagnostic criteria for accessing services would exclude care to women suffering major mental health problems as a result of things like borderline personality response.

Despite the fact that the consumers in our focus groups had diagnoses of major mental illness, they still advocated that the mental health system have a broader mandate in order to help prevent the development of serious mental health prob-lems. Some of our respondents, however, felt that since the mental health system in recent times has ignored the needs and concerns of people with chronic and persistent mental illnesses that it was essential that resources be re-allocated to this population.

At the heart of this debate are two concerns. The first concern is about how to define "seriously mentally ill" and the second is about where resources should be allocated in a climate of fiscal constraint.

Debates about involuntary treatment

These debates centre on whether or not there are ever situations in which it is appropriate to force treatment on an individual and the extent to which the government should legislate and regulate involuntary treatment. This debate most often arises in situations where individuals who have been diagnosed with a mental illness decide to forgo treatment and are perceived by their caregivers and/or family members to have a poorer quality of life as a result of refusing treatment. This debate is heightened in situations where individuals are seen to be a danger to themselves or others.

On the other side of this debate are many psychiatrized women who feel that forced treatment overrides their civil and human rights and is a paternalistic and socially controlling response to individual choices about psych-iatric treatment and lifestyle.

Debates about the utility of a bio-medical model for understanding mental health problems

There is a wide range of both experiential and clinical debate about the utility of the bio-medical model with its attendant use of psycho-pharmaceuticals for understanding and treating mental illness. The majority of our participants felt that a combination of biological, social and psychological explanations are needed to understand mental health problems. These respondents were most often in favor of the availability of a wide range of treatment options for women.

Anti-psychiatry activists, on the other hand, draw attention to the predominance of the bio-medical paradigm and the ways in which the practice of psychiatry is interdependent with the pharmaceutical industry. These individuals often reject the use of medication and other traditional psychiatric treatments.

In this section, we begin with a brief summary of the concerns raised by each group of our research respondents (caregivers, service providers and consumers). This summary is followed by a more detailed discussion of the concerns most often raised by our respondents. Barriers to accessing services, re-victimization in the system, treatment of choice and the impact of violence and trauma on mental health emerged as the most significant issues overall. In each of these sections the perspectives of consumer survivors, service providers and women caregivers are integrated.

E. Key Concerns

Key Concerns for Women Consumers

· Barriers to accessing services

· Re-victimization in the system

· Treatment of choice

· The impact of violence and trauma on mental health

Key Concerns for Service Providers

· The impact of mental health reform on service mandates

· Lack of resources to provide women-specific programming

· The need for alliances between

Women indicated that their physical complaints were often dismissed as psychosomatic or "all in their heads" or, conversely, concerns they had about their mental well-being were often trivialized or reduced to their physiology as women.

anti-violence workers and mental health workers

Key Concerns for Caregivers/ Family Members

· Education for professionals about how to include families in treatment planning

· Access to counselling, support and respite services

· Recognition that the burden of caregiving falls to women

F. Barriers Affecting Access to Service Provision

One woman who had a dual diagnosis (i.e., dissociative identity response/bi-polar response) indicated that two significant barriers existed for her. One was that because of the lack of understanding, skills and experience in treating multiple or dissociative responses, many mental health care professionals were hesitant to help her. Additionally, she had been turned down for care by the local mental health team who perceived her as high-functioning and able to manage her own case. Although this had given her a lot of control over her own

situation, she indicated that in times of crisis she really needed support that she could not access: "When I need help, I NEED help. I need to build a relationship with my general practitioner now so that when I say I need help, that door doesn't close."

Women in our focus groups entered the mental health system in a variety of ways. Most often women came in through an emergency crisis (e.g., hospital admission or hospital emergency room) although some women were also referred by a general practitioner.

Under-service

Women in our focus groups spoke about how they had been refused treatment or about how they felt under-served by the mental health system. In many cases this appeared to be a result of the particular mandates of services. For example, some women suffering from serious mental health problems told stories about being turned away from emergency because they did not fit commonly used diagnostic criteria for accessing services.

"It was NOT helpful to be in a care facility with men when I was in crisis and was trying to leave my abusive husband."

This barrier appears, in part, to result from the focus of current mental health resources on individuals who are diagnosed with "serious mental illnesses" or who suffer serious impairments as a result of their condition. Concerns were expressed about how this determination is being made by service providers who are often working without adequate resources. That is, service providers may not be able to fully assess an individual and may therefore make their decisions about who can access services based only on an individual's psychiatric diagnosis. Since women are more often diagnosed with affective responses, personality responses and post-traumatic stress response — all of which are considered "less serious" — we heard concerns that these British Columbian women will not be able to access adequate supports under new mental health plan guidelines.

Insensitivity/Inadequate Attention to Physical Health Care Issues

A related issue is women's physical and mental health concerns not being taken seriously by their general practitioners. Women indicated that their physical complaints were often dismissed as psycho-somatic or "all in their heads" or, conversely, concerns they had about their mental well-being were often trivialized or reduced to their physiology as women.

Transition House Mandates

A further barrier to access, but this time, access to women-serving organizations, occurred for women who were experiencing violence in their intimate relationships and have mental health challenges. Concerns about resident safety and appropriate staff training means that some transition houses are reluctant to house women with serious mental health problems. Very few transition houses in Canada are specifically designed to support women who have been diagnosed with mental illnesses. Transition house workers recognized this limitation of their services and called for more training and support to house women with serious mental health challenges. An initiative is currently underway in British Columbia which will bring women-serving organizations together with mental health

workers to learn how they can better support women with mental health challenges.

Other Barriers

Across the province and particularly in rural areas there is a dearth of mental health services that are either designed to assist women from non-European Canadian backgrounds or provide generic services with an awareness of the particular concerns of diverse groups of women.

Many women noted that they did not feel comfortable using services, such as drop-ins, clubhouses or supported independent living environments, all of which disproportionately serve men. A woman in a rural area said, "It was NOT helpful to be in a care facility with men when I was in crisis and was trying to leave my abusive husband."

Finally, financial barriers provided a significant deterrent to women wanting to access services outside of the formal mental health system, including long-term counselling.

Recommendations

· Recognize that mental health problems exist along a continuum and ensure that the current targeting of resources to the "seriously mentally ill" does not result in discrimination against women. If access to specific types of services (e.g., hospitals) are to be further restricted, more community support options must be made available to those who fall outside the mandate.

· Broaden access and response to a diverse range of women. Access issues for women for whom English is not a first language or for whom other cultural barriers might exist are complex. Anti-racism and diversity training is needed for mental health workers. The promotion of alliances between mental health organizations and organizations working with specific populations is necessary.

G. Re-Victimization in the System

In some communities where the local hospital does not have a psychiatric unit or trained staff, jail cells are used to hold women until they can be transported to

the nearest psychiatric hospital. Women were often chemically restrained through medication, in such instances.

Feminist writers have documented a wide range of abuses in the system – ranging from the ways in which women are patronized by male medical professionals to the ways in which their claims are dismissed (Ehrenreich & English, 1973; Caplan, 1985). In addition, feminists have written about physical and sexual abuse by professionals (Davidson, 1997; Firsten & Wine, 1990; Penfold, 1998). Additionally, there has been discussion about the violence committed against women by male patients or visitors, due to inadequate safety provisions in institutions and on acute care wards.

Discussions about violence and abuse within the mental health system has also focused on debates about the use of physical and chemical restraints (Shimrat, 1997; Lyons, 1999) and the use of electroconvulsive therapy (ECT). Despite the many dangers of ECT and no definitive evidence that it alleviates psychiatric symptoms, it continues to be

used as a treatment for severe depression and is most often used as a treatment on elderly women (Bohuslawsky, 1999).

Physical and chemical restraints appear to be routinely used in acute mental health crises. Women also described instances in which chemical constraints and electroconvulsive therapy (ECT) were used in ways that they felt were directly punitive of a behaviour a doctor did not like. All of the regions we visited, with one exception, have hospitals with isolation rooms that were also routinely used. Although it is recognized that these rooms are often used to protect aggressive and suicidal individuals, uniformly, women and service providers indicated that these rooms could use improvement. Most are very barren and have no toilet facilities. In one rural community we heard of a woman who was held for three days in a seclusion room because no beds were available. She had no access to a toilet except by escort and the toilet was visible on a video monitor at the front desk.

The women and service providers in our study were split in their views about the need for chemical

The mental health system predominantly responds to mental health concerns through the prescription of psychotropic medications.

and physical restraints and for isolation rooms. However, all agreed that the accompanying indignities (e.g., being stripped of one's clothing, being handled roughly, etc.), were re-traumatizing and felt that more humane ways were needed to help calm people in acute crisis. The use of restraints, especially for women with histories of sexual violation or abuse, can be further psychologically damaging (Smith, 1995). Deaths and injuries through the use of restraints have been documented (Weiss, 1998).

Several of our participants revealed they had been sexually abused by a professional. The consequences of this abuse were substantial, often resulting in further mental health problems and a reluctance to seek help.

Women in our study characterized some of the ways in which they were prescribed medications as abusive. In particular, some women felt that psychiatrists and general practitioners prescribed medications without giving adequate information about important side effects or interactional effects with other drugs (e.g., loss of sex drive,

lactation, no menses, sedation) and sometimes dangerous side effects (e.g., permanent changes to the brain, tardive dyskinesia[22]). Others felt that they were being used as "guinea pigs" to test new drugs on the market.

In smaller communities where there are no resident psychiatrists and individuals are dependent on twice-monthly visits, medications were often monitored by general practitioners who did not have the special training to ensure that symptoms, side effects and medication dosages were appropriately monitored.

Recommendations

· Participatory treatment models should be established which would allow psychiatrized women to have advance input into treatment planning should they be unable to make decisions during an emergency crisis. For example, women should be able to have input as to what kinds of treatment they would authorize in an emergency.

· Establish less intrusive alternatives to the use of restraints,

Trauma and violence in women's lives can be both a precursor to psychiatric diagnoses, and a complicating factor for women already experiencing mental health difficulties.

isolation rooms and ECT. Restraints, isolation rooms and ECT should never be used as punitive measures or for staff convenience. There are examples where staff of institutions have received training to enable them to effectively work without the use of restraints.[23]

· Institute a zero tolerance policy for sexual abuse. Sexual abuse by medical and mental health professionals is unacceptable and should be prosecuted. Given that women with mental health challenges are more vulnerable to abuse (in part, because their credibility would be questioned should they report), much stronger measures are needed to protect women and to enforce professional codes of ethics. The Task Force on the Sexual Abuse of Patients, commissioned by the College of Physicians and Surgeons in Ontario in 1991, is an example of an attempt to monitor and address this problem.

· Women must be advised of the risks of medications. Mental health professionals need to clearly advise their patients of the health-related risks of psychotropic medications[24]

and be able to provide information about how to safely come off medications. Wherever possible, complementary therapies and alternatives to medication should be tried.

Additionally, more research is needed to determine the impact of medications on women's normal life cycles (menses, menopause, pregnancy). For example, research suggests that the peak hospital admission time for women with diagnoses of schizophrenia is at childbirth (Women and Mental Health Working Group, 1996).

H. Treatment of Choice

One woman who had been using alternatives to medication for several years and was feeling very good noted, "I was not supported in this by my general practitioner, but I am taking more responsibility for my own health. And this was seen as radical in how you live your life!...Recovery is never seen as a possibility, just management."

The mental health system predominantly responds to mental health concerns through the prescription of psychotropic

medications. Concerns about over-medication, especially of elderly women (e.g., Oglov, 1998), and of inadequate research into women's responses to psycho-tropic medications have been raised.

Within the current system, despite a commitment to a "bio-psycho-social" framework, the first response to women is primarily one of clinical assessment and treatment through pharmaceuticals. There is much evidence to suggest that there is a rise in bio-medical treatment models and that psychiatry is increasingly being directed by the support of major drug companies. According to the IMS Health and Information Company which measures pharmaceutical industry sales, psychotherapeutic drug sales are booming and represent the second most common class of drugs prescribed in Canada (IMS, 1999 cited in Fayerman, 1999).

Consumers active in the anti-psychiatry movement (Shimrat, 1997; Capponi, 1992 & 1997; Blackbridge & Gilhooly, 1985), some mental health professionals (Cohen & Jacobs, 1998;) and even psychiatrists

have questioned the predominance of biological explanations for mental illness (Breggin, 1991; 1994; 1996; Kaiser, 1996).

Within the current mental health system psychiatrists are the most widely recognized experts and often the only ones to whom women have free access. This situation perpetuates a medical response to mental illness and has created a two-tiered system in which women with money and resources can access a much broader range of treatment options than can women with lower incomes.

Recommendations

· Ministers of Health in each province must examine types of medical/health services that are covered or subsidized through medical service plans and take steps to include alternative and complementary therapies and counselling.

· Mental health providers must facilitate women's active participation in treatment planning. Women must be supported in their choice of treatment options whether this consists of medication, alternative and/or

In some rural communities it was almost routine for individuals experiencing an acute psychiatric crisis to be jailed until other supports could be found.

complementary therapies or the use of traditional healing practices.

I. Trauma, Violence and Mental Health

One young Aboriginal woman described the abuse in her life and its consequences: "Suicide is a big problem here. We're told to keep silent, that we are babies if we talk. I lost my best friend and then finally got help. I want to be a grandparent, I want to see that my daughter gets help. I reached out last week because I didn't want to commit suicide. I held on to that rope and that same day my cousin hung himself. I think of my mom. She was in an abusive relationship and stayed with him for years. She was always told to stay there and stand beside him. I was in an abusive relationship for seven years and my mom told me to stay, that it will get better. I am now the only parent to my kids. I drank after an abusive experience and had an accident and the father of my kids died. I am tired of all of it. I want better things out of life."

Trauma and violence in women's lives can be both a precursor to psychiatric diagnoses, and a complicating factor for women already experiencing mental health difficulties.

Numerous studies have found that sexual and physical abuse histories are common among women and girls who have been diagnosed with mental illnesses (Swett & Halpert, 1993; Fisher, 1998; Alexander & Muenzenmaier, 1998; Muenzenmaier, Meyer, Struening & Ferber, 1993; V/RHB Women's Health Planning Project, 1999; CMHA, 1993). For instance, a study of trauma histories among women and men at British Columbia's provincial psychiatric hospital, Riverview, revealed that large numbers of women have histories of physical and sexual abuse: 58 per cent of women had been sexually abused before the age of 17 (Fisher, 1998). Temi Firsten (1991) in her study of women psychiatric inpatients found that 83 per cent had experiences of severe physical or sexual abuse as children or adults. What these studies suggest is that symptoms of trauma may be misdiagnosed as mental illnesses. Further, these studies suggest that more investigation is needed to understand

The main impetus for case management/ ACT must not simply be the freeing up of hospital beds, but rather a progressive treatment approach that will ultimately improve the quality of life for women who have serious mental health challenges.

the role of violence and trauma in the etiology of mental illness.

Many of the women in our focus groups disclosed that they had histories of having been physically or sexually assaulted either as children, as adults or both. For some women the abuse was ongoing at the time of the focus group. Evidence that experiences of violence were often what brought women into the mental health system was apparent. Many of these women described symptoms that are associated with responses to abuse and with the coping methods used to deal with abuse (e.g., depression, disassociation, anxiety or substance use). Women reported that they were rarely asked about their experiences and rarely disclosed abuse in initial contacts with mental health professionals. Their symptoms were often psychiatrically diagnosed and medications were prescribed. One woman noted that when she volunteered that she had been abused, she was told by her psychiatrist that it was all a bad dream, even though she had physical injuries.

Women who are experiencing mental health problems are often more vulnerable to sexual and physical abuse. For example, women in our focus groups indicated that histories of trauma and violence made it difficult for them to articulate personal boundaries when living in institutional settings.

Recommendations

· Train mental health workers in recognizing women's responses to violence and trauma. Mental health professionals must be educated to understand that violence and trauma are often precursors to mental health problems and that violence can exacerbate already existing mental health problems. Forms of support are required which do not employ intrusive or coercive measures (Whipp, 1992).

· Train anti-violence front-line workers to provide support to women who have mental health problems and who are also experiencing violence.

· Provide support for long term counselling and peer support groups for women with mental health issues. There is an

Inpatient and outpatient programs, like community supports, must reflect the needs and concerns of women.

overwhelming need for long term counselling, especially for child sexual abuse survivors. Peer support groups were also indicated as very helpful in coping with trauma and violence histories.

· Implement supportive training programs for mental health care consumers to help them better understand the impact of violence on women and to develop assertiveness skills that will help keep them safer.[25]

J. Crisis Response/ Emergency Services

In some rural communities, crisis response was not confidential due to the use of scanners by the public to monitor calls to the police. Women indicated reluctance to engage emergency response under these conditions. It was speculated that this would have a particularly silencing effect on women whose partners were violent.

Crisis services typically include: crisis lines, crisis response teams, hospital diversion/rapid return to hospital programs, community or hospital-based day and evening programs and

emergency/short stay residential facilities (BC Mental Health Plan).

Crisis responses are poor and inadequate in some regions and are experienced by some women as further traumatizing. In some rural communities it was almost routine for individuals experiencing an acute psychiatric crisis to be jailed until other supports could be found. In general, psychiatric hospitals' crisis responses were experienced by women in our focus groups as punitive rather than helpful and supportive.

In many rural and northern communities the crisis lines are local and only available during daytime hours; after hours they are switched to the police or crisis unit in the nearest urban centre. Some smaller communities were totally dependent on crisis lines in other cities day and night. Local support was often not available. The result was extreme delays in service response.

⟶ Recommendations

· Put advocates/support people in place in hospitals. Trained individuals are needed in each hospital to prevent the use of jail

cells for women in a psychiatric crisis. These people would ensure that an individual in crisis is treated with respect and kindness and that restraints are only used in the most serious situations (i.e., if a person is in serious danger of hurting herself or others). A number of women in our focus groups wanted to have access to more outreach teams: individuals who could come to them in a crisis and stabilize them. One possible model is that used by the Gerstein Centre in Toronto or a modified Assertive Community Treatment (ACT) program as discussed below.

· Provide confidential crisis response in every community. Local general crisis lines need to build better capacity for responding to women with mental health difficulties.

K. Case Management/ACT

More monitoring may not directly translate into more care, but instead might mean that further punitive measures (e.g., child apprehension) are taken against women with serious mental health challenges.

Case management in the form of Assertive Community Treatment (ACT) was first introduced in the United States 10-15 years ago. Although case management approaches and interdisciplinary mental health teams have been part of the Canadian mental health system for some time, ACT programs have increasingly come to be implemented in a Canadian context. ACT is an approach that involves the use of a team rather than individual case managers to provide ongoing service to clients who need high levels of support. The idea is that a team is better able to address the multiple aspects of a person's mental and physical health. Care is typically taken to the location of the client. ACT is characterized by a worker to client ratio of approximately 1 to 10. Due to the intensity of this case load, true ACT is viable only in communities where there is a large population of people with serious mental health problems.

Proponents of ACT indicate that it is a comprehensive treatment program which prevents re-hospitalization and is particularly effective for a small sub-set of people who need intensive supports.

Societal attitudes and widespread myths and stigma surrounding mental illness continue to perpetuate the belief that women with mental illnesses are incapable of having and caring for children.[26]

Since research suggests that for many women their ability to maintain custody of their children is often critical to their recovery, support for maintaining custody or access to their children is needed (Zemenchuk, Rogosch & Mowbray, 1995).

Critics of ACT point to its bio-medical bias, in particular, its focus on medication compliance, and the concern that it can become coercive. Some even suggest that it may prevent rather than pro-mote the building of community supports for individuals with serious mental health issues (Spindel & Nugent, 1998). ACT has been described as, "the first step towards the imple-mentation of much harsher measures targeting persons who have been labelled 'mentally ill'. Such teams can be expected to play a major policing role in the lives of psychiatric survivors" (Weitz, 1998). This is of particular concern to women who are trying to come off medication who may go through a period of deterioration in the interim.

The majority of the participants in our focus groups were not receiving ACT, so experiences and opinions on its usefulness were not available in every jurisdiction. However, it is clear that women are asking for a broader range of treatment options including ones that take a more holistic approach.

Ideally, ACT could play this role because of its multidisciplinary nature. However, care would need to be taken to actually tailor all case management to the needs and wishes of the individual without allowing it to be reduced to a monitoring system that en-sures medication compliance.

Recommendation

· Design ACT to be multi-disciplinaryand tailored to indi-vidual needs and self-identified goals. The main impetus for case management/ACT must not simply be the freeing up of hospital beds, but rather a pro-gressive treatment approach that will ultimately improve the quality of life for women who have seri-ous mental health challenges. For case management/ACT to work, consumer survivors must be employed to design and deliver services.

L. Inpatient/Outpatient Care and Institutional Care

In most inpatient and outpatient settings there is no programming specific to the needs of women. Women in our focus groups indicated that this would be useful, especially for women

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structure.

who come into the mental health system as a result of trauma and abuse.

Inpatient/outpatient care covers a wide range of service provision including acute psychiatric care, long term care and community-based tertiary care. If an individual is seen as needing a higher level of long term cares he is sent to a psychiatric institution. The deinstitutionalization of persons with mental health challenges has put additional strains on hospital and out-patient services.

The vastness of certain regions and the isolation of some communities has made the establishment of mental health inpatient and outpatient services difficult. Services in these areas are often sporadic, fragmented and lacking. The transient nature of the professional population in smaller communities means that women find it very difficult to establish trusting relationships with service providers.

Many of the women in our focus groups had spent substantive amounts of time in psychiatric institutions. Most reported that there was a dearth of program-

ming specific to women and that the specific needs and concerns of women were ignored. A review of programming at British Columbia's major psychiatric institution, Riverview, revealed that no women-specific programs exist.

⟶• Recommendation

· Inpatient and outpatient programs, like community supports, must reflect the needs and concerns of women. Women-specific programming is necessary, especially for women with trauma and abuse histories and women with dual diagnoses.

M. Vocational/Educational Supports

Women in our focus groups indicated that a lack of accessible, affordable child care meant they often could not attend rehabilitation or education programs.

Traditional vocational training often replicated discrimination in the wider job market by training women only for jobs traditionally taken by women (Traustadottir, 1990). In general, former mental health consumers are concen-

Many of the caregivers we spoke with felt that they were "left out of the loop" by the mental health system in being able to gain access to their family member or get information about support and treatment plans.

trated in low-paying jobs with no possibility for advancement.

The need for vocational/education supports for women with serious mental health challenges is integrally connected to the need for women to have adequate incomes to support themselves and their children. Women are chronically unemployed due to gaps in education and skill building.

Some women are unable to work in full time jobs and therefore require either flexible employment opportunities or access to meaningful forms of activity.

⟶• Recommendations

· Vocational training programs should adhere to the principles of employment equity and train women for jobs that will allow them to realize their greatest potential.

· Improve access to supportive employment and education programs. Such programs would include a focus on building self-esteem and broader social interactions. These programs would either lead to employment that would improve women's

economic stability or allow women a better quality of life.

· Provide adequate income assistance to women who are unable to work. Women must have access to income assistance that is appropriate to their needs, including access to disability benefits (British Columbia Coalition of People with Disabilities, 1998).

N. Pregnancy, Parenting and Mental Health

"Once when my children were little, I had a [manic] breakdown. I avoided getting help because I didn't want to be separated from my kids. Finally I went to the hospital. My GP [general practitioner] was so supportive, he understood my need to be with my kids. He gave me some meds, let me sleep and gave me a sense of support and self-worth. He even arranged for a homemaker and nurse for me and my kids. It was a turning point in my healing."

Societal attitudes and widespread myths and stigma surrounding mental illness continue to perpetuate the belief that women with mental illnesses are incapable of having

and caring for children.[26] More often women with mental health difficulties were seen as unable to care for their children. Many of the women in our focus groups had lost custody of their children – some felt this was a discriminatory act based on myths that people with mental illnesses are dangerous. Some women indicated that they were afraid to reach out for help because they did not want to lose their children. Women who recognize their inability to care for their children often find that separation planning is traumatic and ill conceived, with little attention to the grief and loss women experience in losing custody of their children.

Recommendations

· Women's roles as mothers must be recognized and supported in mental health treatment and planning.

· Provide appropriate and sensitive care to women facing custody issues. Since research suggests that for many women their ability to maintain custody of their children is often critical to their recovery, support for maintaining custody or access to

their children is needed (Zemenchuk, Rogosch & Mowbray, 1995). Where full custody is not possible, women should be empowered as much as possible and have the least traumatic separation plans with follow-up and support.

O. Substance Use and Mental Health

One long-time drug and alcohol worker on a reserve indicated, "It's a privilege to be here and to share with you about keeping your sanity as a worker. I worked for 30 years as an alcohol and drug counsellor, as a coroner and as a social worker. When necessary I also apprehended children and I have no words to express the sadness this brings…There are so many suicides here but nothing is done – there aren't any workshops. I have offered to help but people turn to alcohol and drugs for relief."

Substance-use issues often accompany mental distress. Across the province there appeared to be very little understanding of the specific needs and concerns of women who have been dually diagnosed. Although centres for dual diagnoses

were found in most major cities, very few if any of these had women-specific programs. Most resources for substance use are not designed to help women who have a mental illness diagnosis. Most major psychiatric hospitals do not have substance-use treatment sources on site.

⎯◕ Recommendations

· Establish programming that recognizes the interconnections between substance use, mental health problems and histories of physical and sexual abuse.

· Develop non-punitive policy to deal with the needs and concerns of women who have been dually diagnosed. This is especially critical given coercive legal solutions in some Canadian jurisdictions that have mandated pregnant women into treatment.

· Amendments to Mental Health Acts in Canada should be reviewed to ensure that criteria for committal is properly interpreted and does not discriminate against dually diagnosed women who are mothers.[27]

P. Consumer Initiatives & Peer Support

Many women indicated that what helped make the difference for them were other people who had had similar experiences, supporting and guiding them through their difficulties. This was particularly true for women who had attended support groups related to child sexual abuse. Peers were seen as being able to provide validation, support and compassion. Although some women valued the support they received in co-ed settings, many women indicated that women-only groups were a necessary part of healing for them.

Although consumer involvement in policy making, and government-sponsored agencies and con-sumer-run projects are relatively new, the activism of consumer survivors and the development of consumer survivor networks is not. These groups emerged historically either as part of the burgeoning self-help movement which dates back as far as the 1930's (Trainor, Shepherd, Boydell, Leff & Crawford, 1997) or in opposition to psychiatry and bio-medical models.

The success of consumer survivor initiatives in helping individuals reach wellness has been well documented in a study which examined projects funded through the Consumer/Survivor Development Initiative which was initiated in 1991 in Ontario (Trainor et al,1997). The study found that consumers involved in consumer survivor initiatives used considerably fewer mental health services (especially crisis intervention and hospitalization) and reported that their involvement had increased their self esteem and their ability to make social contacts.

——• Recommendations

· Peer support groups should be recognized and financially supported as a necessary component of the mental health service structure. In most communities we visited, the success of support groups was dependent on one dedicated professional or consumer. These groups were constantly threatened by lack of resources. Examples of successful groups include the Vancouver/Richmond Mental Health Network located in Vancouver.[28]

· Provide supports that will allow consumer initiatives to succeed. Women pointed out that consumer initiatives without adequate supports were useless. One key informant suggested consumer initiatives are often "set up for failure" because the needs of consumers are not recognized. For example, consumer survivors, because of prolonged mental health challenges or institutionalization, may have missed out on educational and skill-building opportunities which would help them run programs. The need for support was evident, but so was the need for consumer survivors to be in control over planning and the money they receive for initiatives.

Q. Family Support

An immigrant women in one of our focus groups indicated that when she arrived to visit her son in hospital after several weeks of mental health care, he was being transferred to Riverview without her knowledge. Service providers gave her no explanation for his sudden transfer and she was left on her own to figure out where Riverview was located and how to contact her son.

Many of the caregivers we spoke with felt that they were "left out of the loop" by the mental health system in being able to gain access to their family member or get information about support and treatment plans. Caregivers called for stronger communication mechanisms that would allow them to follow their family member through the system and be more involved in treatment planning.

Women caregivers discussed the emotional and physical costs of caring. Caregivers expressed the need for more financial and emotional supports for their work.

⟶☺ Recommendations

· Recognize that the burden of caregiving falls principally to women. Governments must recognize and financially support the work of caregivers.

· Caregivers must have access to respite and other support services such as counselling.

· Recognize the role of peer support and provide adequate financial means to implement programs.[29]

· Acknowledge and value the multi-faceted roles of women family members and caregivers.

VI

Diversity Issues

Women-centred principles and values explicitly recognize the diversity of women and the importance of developing service provision and policy that takes into account this diversity. Further, because some groups of women have been particularly marginalized, all discussions of diversity must explicitly acknowledge that other forms of discrimination outside of sexism impact women. In this section we explore the particular concerns and issues of specific groups of women and make recommendations which are consistent with women-centred values and principles.

A. Women Living in Poverty and Low-Income Women

Several women in our focus groups described how difficult it was to deal with chronic mental health problems and care for their children without adequate financial resources.

As already discussed in this paper, income has a significant impact on the types of services a woman has access to and the degree to which she can maintain her own autonomy and privacy. A two-tiered mental health system exacerbates the problems experienced by this group of women. The result is that the lives of low income women and women living in poverty are more often regulated by mental health professionals and punitive measures (such as forced treatment or apprehension of children) are more often used against them.

·—• Recommendations

· Recognize that poverty disproportionately impacts women and their children, especially elderly, unattached women.

· Acknowledge that poverty is a systemic social problem, not a problem of individual motivation or circumstances.

In Canada, there has been a systematic erasure of Aboriginal healing practices and there is much evidence to show that people of colour and immigrant peoples have historically been pathologized and controlled through the practice of psychiatry.

· A wider range of mental health supports and treatments must be publicly funded so that all women, regardless of income, have access to them.

B. Women of Colour and Immigrant Women

The inaccessibility of services due to the lack of translation and cultural interpretation services was very apparent. There is no health policy in place which mandates translation so that women who do not speak English can access adequate mental health services. Translation services were completely un-available in many areas and ad hoc at best. Women relayed stories of being in acute crisis in the hospital where cleaning staff who happened to be close by were called in to translate. In the 1997 Eldridge case, three hearing impaired people won the right to access sign language interpre-tation for hospital-based health care in the Supreme Court of Canada. This Charter test case has wide-reaching ramifications and could apply to the provision of interpretation for all languages.

Discussion and understanding of mental health and mental illness vary from culture to culture. In some Aboriginal cultures, for example, a person experiencing hallucinations or hearing voices might be considered a visionary with special spiritual insight. In some Asian cultures individual treatment models which do not reflect the interconnections between family members and the community are inappropriate. Despite this, Western psychologi-cal and psychiatric frameworks and treatment procedures have come to dominate medical practices worldwide.

The authors of an extensive critique of Western psychiatry state:

While colonial and imperial traditions served political and economic purposes, psychiatry along with other Western sciences provided the "scientific" rationale for legitimiz-ing colonization by supporting the myth of the inferiority of "Third World" peoples (Boyer et al., 1997).

In Canada, there has been a systematic erasure of Aboriginal healing practices and there is much evidence to show that people of colour and immigrant

The impact of racism and of the settlement process on the mental health of new immigrants and people of colour has been well documented in several important Canadian reports.

peoples have historically been pathologized and controlled through the practice of psychiatry. There is no formal recognition of different perspectives on mental health and illness and in the formal mental health system everyone is offered the same type of treatment and responses. However, in recent times some organizations and programs have been designed to respond to the specific needs of a particular community; however, few if any of these organizations are recognized as part of the formal mental health system.

The impact of racism and of the settlement process on the mental health of new immigrants and people of colour has been well documented in several important Canadian reports (e.g., The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Culture and Health 2000, 1995; Boyer et al, 1997). Several women in one of our focus groups noted that their entry into the mental health system was precipitated by cumulative experiences of racist treatment and their difficulty in adjusting to a new culture and society.

Despite this, racism and settlement issues are not routinely recognized as having mental health consequences and these issues have not been addressed in the mental health system. In our focus groups with service providers many were reluctant to identify racism as an issue worthy of considered attention. They also indicated that their organizations were inadequate in their ability to respond to ethnocultural diversity with respect to the provision of services.

In convening our focus groups we found it difficult to access the views of women from non Euro-Canadian backgrounds, except in the case of Aboriginal women (discussed below). In some instances, where we had links to immigrant communities or communities of people of colour, women were hesitant to come forward and share their views because of the stigma of mental illness in their community. Although this was not explicitly stated, some women may have been uncomfortable speaking about their concerns because of their experiences of racism. Additionally, our key informants indicated that many immigrant

Develop an anti-racist holistic approach to mental health care to serve the needs of different ethnocultural communities.

women do not access "mainstream" or "generic" services. Other studies have affirmed this point, that is that these groups of women are very reluctant to seek help and when they do it is as a last resort (Boyer et al, 1997).

The information presented here comes from the immigrant women and women of colour who did attend our focus groups or who agreed to be interviewed as key informants. It also comes from the one focus group we held with Chinese Canadian women.

Women who were recent immigrants in our study experienced barriers in trying to access mental health services. The barriers most often described included stigma, language and cultural barriers.

Some women felt that the stigma of mental illness in their community and the lack of knowledge about mental illness contributed to isolating women from outside sources of support. Other women noted isolation and a lack of knowledge about the Canadian mental health system as barriers to accessing services. This was true for recipients of services as well as for women caregivers. A

number of women, who were not yet Canadian citizens, cited fears about deportation, should they be hospitalized, as a reason for not accessing the mental health system.

Women indicated that very few, if any, culturally appropriate services exist in their community. Most services of this nature are found in larger urban centres and are generally in the form of support groups that have either been started independent of government funding by committed individuals or exist as adjuncts to other generic forms of service; some of which are not mental health related.

✎ Recommendation

· Develop an anti-racist holistic approach to mental health care to serve the needs of different ethnocultural communities. Existing ethnocultural organizations and support groups must be well funded and connected to the rest of the mental health system. Comprehensive strategies are needed to educate mental health care service providers on the impact of racism and settlement on mental health.

The impact of residential schooling and the abuse of Aboriginal children within these institutions is only just beginning to be understood.

Work being done by the group Culture and Health 2000,[30] which involves documenting the concerns of people of colour and immigrants, and by the Across Boundaries Mental Health Centre in Toronto, is critical. Information about existing mental health services and especially about consumer survivor networks must be made available to women in all ethno-cultural communities.

C. Aboriginal Women

In our groups with women who are Aboriginal the level of physical and sexual abuse experiences were very high. In the focus group we conducted on reserve, suicide was one of the overiding issues that the community was dealing with. Almost every member of this particular group had lost a family member or friend to suicide. One woman noted, "The government uses this community as guinea pigs to study suicide issues and to get publicity. The Mayor says that the suicides are because of the collapse of fishing, but that is not true. Every one of us has probably tried to commit suicide, one way or another."

Some of the themes elaborated earlier are true also for Aboriginal women. That is, barriers to service include the lack of culturally sensitive services and a lack of recognition by mental health care providers of the impact of racism. In the case of Aboriginal women, the barriers include the legacy of colonialism and its impact on mental health. One women noted that mental distress in her community resulted when their main cultural practice, the potlatch, was banned and she and her community were forcibly assimilated.

The physical and mental health concerns of Aboriginal people are bound to differ from the concerns of Euro-Canadian people. The impact of residential schooling and the abuse of Aboriginal children within these institutions is only just beginning to be understood. Additionally, statistics show that Aboriginal women are more likely than non-Aboriginal women to be incarcerated (Lepischak, 1992).

The rate of drug and alcohol abuse in Aboriginal communities was also very high. One woman said that when she went into a recovery centre in the U.S. and

Recognize historical and continued abuses that lead to mental health challenges for Aboriginal women, and provide support, recognition and resources for traditional healing practices.

told her story to the counsellor, the counsellor said she had lived "a horrific life," to which she replied, "but on the reserve that's normal, everybody has the same kind of life."

Many women spoke about difficulty in accessing services. One reason for this was their experience of the racism of service providers. In one community women travelled great distances to a hospital, despite the fact that there was a local hospital in town, because they perceived the staff to be racist.

Other women indicated that they didn't know what services were available. This was compounded in some communities by jurisdictional issues. Aboriginal bands get their own federal money for health, but they technically also have access to all provincial health services. Women in one reserve community indicated, however, that some doctors in town would not serve them if they were "treaty".

Lack of follow-up services on reserve were also mentioned. One service provider noted, "If women are really suicidal they go to the hospital and stay a day or

two and then are sent back into the community without any follow-up. Worse yet, if children are sexually abused or raped the RN's will do a rape kit at the hospital and the Crisis Centre counsellor is supposed to be there, but often there is no follow-up. The hospital doesn't refer them because of fears around the Freedom of Information Act — they can't pass on the information."

Stories of self-help and community- building were common. Aboriginal women in our study were the least likely to have a "serious mental illness" diagnosis, in part, because they did not access resources and instead made more use of peer support.

The multigenerational, multiepisodic traumas were so common among Aboriginal participants that service providers in Aboriginal communities indicated a real need for help with vicarious traumatization.

Recommendation

· Recognize historical and continued abuses that lead to mental health challenges for Aboriginal women, and provide

support, recognition and resources for traditional healing practices. In some communities we visited, Aboriginal service providers were being restricted from instituting traditional practices. One of our key informants recommended the development of "free-standing" Aboriginal health clinics. A service provider proposed a similar notion: "We need a treatment centre that would be a safe place to re-learn skills, that would also be for young moms to learn parenting skills. There they could learn about the effects of abuse from way back…There would be teaching by grandmothers every month about children, cooking and lifestyles so that not just one person had to do all the work. There would be treatment for workers also, about holistic ways and new stuff like aromatherapy, neurolinguistic programming, and timeline therapy. The treatment centre would be [close to the water] because the elders need that connection to the ocean and the healing powers of the water."

D. Older Women

In one community we visited, older women (with the support of a social worker) had developed a series of self-help empowerment groups for older women. Women who had participated in these groups said they had been very helpful in keeping them out of the psychiatric system.

Older women's mental health concerns differ from those of younger or middle-aged women. Older women who have chronic mental health challenges are more likely to have entered the mental health system prior to mental health reform and are therefore more likely to suffer the effects of institutionalization and the side-effects of older psychotropic drugs. Research suggests that elderly women tend to be over-medicated (Oglov, 1998) and to more often receive electroconvulsive therapy (Bohuslawsky, 1999). Women tend to live longer than men and often experience increased mental health problems after menopause. Socio-economic conditions of elderly women's lives, especially poverty and social isolation, have an impact. A recent study suggests that older people, in general, are less likely to get the care they need for mental health problems than are younger people (Habib, 1999).

Older women in our focus groups also discussed the mental health challenges they faced during menopause and indicated that as they aged they faced further discrimination.

—• **Recommendation**

· Recognize and examine further the needs of older women with mental health challenges. For example, an understanding of the effects of psychotropic drugs taken during menopause and on the ageing process is needed.

E. Young Women

The young women who attended our groups spoke about the ways in which they were discriminated against on the basis of their gender and age. They felt they were viewed as children with no rights. Young women who were mothers felt they were more likely to be discriminated against if they were psychiatrically diagnosed. They felt that it was more likely that their children would be apprehended.

Mental health issues for young women include eating disorders and sexual exploitation. In our focus group on reserve, women

reported a very high suicide rate among young women and men. A recent British Columbia report which surveyed young people with serious mental illness diagnoses found that they often go without treatment for up to three to eight years (McNaughton, 1999). The report indicates that young people's mental health difficulties are often misdiagnosed as behaviour problems or substance abuse; as a result almost 60 per cent of the young people surveyed made their first contact with the mental health system at a hospital.

In our study we found a dearth of mental health services specific to young women. Very few services exist for adolescents in general and virtually nothing exists for young women aside from some eating disorder programs. According to our respondents, a lack of specific services for girls and young women combined with the re-organization in British Columbia of Ministry responsibilities for children and adolescent mental health[31] means that young women are often left without services.

Housing issues are also critical for young women who have left home (often to flee physical or

Women in our focus groups indicated that the topic of sexuality (including heterosexuality) was one that was rarely discussed with respect to their treatment or living conditions.

sexual abuse). Women under 16 cannot access subsidized housing. The Ministry of Children and Families has the responsibility of ensuring that young women are housed, but a lack of available spaces makes this very difficult. High rates of unemployment among young women make it very difficult for them to be self-sufficient.

Recognize the particular needs and concerns of women with disabilities who also have mental health challenges.

Recommendations

· Mental health supports specifically designed for young women are necessary. Generic co-ed peer support is not adequate to address the unique issues that young women and girls experience.

· Service gaps that have occurred in British Columbia as a result of the re-organization of ministries must be addressed to ensure continuity of care.

F. Lesbian and Bisexual Women

In our focus groups only a handful of women identified as lesbian or bisexual. As evidenced in our discussions with service providers, a great deal of homophobia exists, especially in smaller rural areas where individuals are unable to maintain anonymity.

Women in our focus groups indicated that the topic of sexuality (including heterosexuality) was one that was rarely discussed with respect to their treatment or living conditions. Within long-term psychiatric institutions women rarely had access to information about safe sex or birth control. Women indicated that having a "mental illness" label seemed to imply that they were asexual beings. As one woman put it, "when it comes to mental health [services] you aren't thought of as having a sexual life."

Homophobia and the lack of lesbian or bisexual role models most profoundly impacts on young women. The suicide rates among gay youth are particularly high (Savin-Williams, 1994). There is a history in the disciplines of medicine, psychiatry and psychology of pathologizing and criminalizing homosexuality. Homosexuality was still listed as a mental "disorder" in the Diagnostic and Statistical Manual (DSM) until 1972.

Evidence suggests that lesbian and bisexual women are still pathologized in the mental health system because of their sexual identities (Blackbridge & Gilhooly, 1985; Savin-Williams, 1994). In our discussions with lesbian and bisexual women it appeared that many women actively avoid mental health services (or revealing their sexual identity) to avoid being pathologized.

Recommendations

· Respect women's sexual diversity in mental health services and planning and provide appropriate supports to women who are exploring sexual orientation or transgender issues.

· Access to birth control and information about safe sex practices should be provided to women in psychiatric institutions and in the community.

G. Women with Disabilities

Many of the women in our focus groups reported physical disabilities that co-existed with mental health challenges. One of their main concerns was that physical and mental health issues are dealt with separately within the system. This had an impact on women in a number of ways. In some instances women felt that their physical problems were in part due to their mental health challenges and, more specifically, to the medications they were taking. In other instances, women felt that physical ailments were misdiagnosed as "mental illnesses". Women indicated that their mental and physical health were so closely linked that they felt holistic treatments would be most helpful.

Other women spoke about accessibility issues and how these created barriers to accessing services. In general, mental health services did not appear to be equipped to help women with physical disabilities and many workers did not have specific training in this area.

Recommendation

· Recognize the particular needs and concerns of women with disabilities who also have mental health challenges. Physical and mental health should be assessed in reference to each other and not seen as wholly separate issues.

H. Criminalized Women

The Coalition of Feminist Mental Health Services indicates, "While women in the criminal justice system have experiences of social, economic and gender-based discrimination in common with many other women, they have manifested these experiences in behaviours which fall outside of socially acceptable parameters and have come in conflict with the law. As a result, they also suffer social stigmatization, a sense of alienation from mainstream society, feelings of guilt, and profound anger towards and mistrust of society" (Lepischak, 1992:8).

Women in the criminal justice system are disproportionately poor and most have had experiences of abuse and trauma. It is estimated that more that 85 per cent of women in prison are survivors of childhood sexual abuse (Lepischak, 1992). Aboriginal women are significantly over-represented in the criminal justice system (e.g., a 1990 survey revealed that 15 per cent of women in Canadian jails serving a term of two years or more were Aboriginal, although Aboriginals account for only 2.8 per cent of the general population). Direct links between imprisonment and poverty have been suggested (40 per cent of all charges against women are related to shoplifting). There is a strong relationship between poverty, experiences of abuse, drug and alcohol use and involvement in the criminal justice system (Lepischak, 1992).

Mainstream mental health services are often not designed to respond to the needs of these women or to deal with anger, self-injury or addictions. Forensic psychiatric services are often not women-specific. In British Columbia the Forensic Psychiatric Institute has recognized this gap and is beginning to develop more women-specific support groups, especially for abuse survivors. The population of women in forensic psychiatric institutions is small, which can make it difficult to ensure specific women's programming.

Of particular concern is the lack of programming for women being released from prison. Women who might have had access to programs while in prison have very little transition support for living in the community.

Recommendations

· In program planning, take into account the particular needs of women diagnosed with mental illnesses who have been in conflict with the law.

· Supports must allow women to access legal counsel and legal aid that is sensitive to their particular legal concerns.

VII

Mental Health Reform

Mental Health reform in Canada can be seen as part of a philosophical shift in the understanding and treatment of mental illness. In more recent years, mental health reform has also been an integral component of health reform in Canada, which has resulted in the re-arrangement of the fiscal and service-delivery structures of health care.

Background

Shifts in the understanding of mental illness are ongoing processes which are embedded in the social and historical events of the day (Foucault, 1973). Prior to the 19th century, people with mental illnesses were often held in prisons or helped in isolation by their family members. In the 19th century as part of larger broad-based social reform movements, psychiatric hospitals were built in what was considered a more humane response to mental illness. Psychiatric hospitals not only quickly became the repositories for any individual experiencing acute mental health problems, but also for those whose behavior or activities did not fit the social norms of the day. After World War II, psychotropic medications began to be developed and there was an effort to institute more preventative and therapeutic models.

During the 1960s and 70s, social upheaval in North America facilitated the emergence of the community mental health movement and the development of non-psychiatric based therapies. Anti-psychiatry activism by ex-psychiatric patients began to highlight abuses that occurred within psychiatric institutions. At the same time, and some would argue as a direct response to these developments (e.g., Breggin, 1996), there was a rise in bio-medical models for understanding mental illness.

De-institutionalization

The community mental health movement and the development of drug treatments were both contributing factors in the move to de-institutionalize persons with mental illness, with a focus on re-integration into the community. In Canada, insufficient preparation for the consequences of de-institutionalization and a lack of commitment to community-based services, meant that many of these individuals, especially those with chronic and persistent mental health problems, ended up living on the streets of larger urban centres or were otherwise without proper care, adequate housing, finances or employment.

Community mental health centres and general hospital psychiatric units began to develop programs for previously untreated populations (the so-called "worried well") and began to ignore the population that was traditionally served by psychiatric hospitals (Canadian Nurses Association, 1991). The result was a two-tiered system of mental health care where middle and upper income individuals usually accessed general psychiatric units and private psychiatrists or psychologists, while lower income individuals, those living in poverty, or those involuntarily committed, tended to be housed in larger psychiatric institutions or went without any care (Richman & Goodrich, 1984).

In British Columbia there have been several revisions of a plan which attempted to facilitate the de-institutionalization of individuals from Riverview, British Columbia's large psych-iatric institution, through the re-organization of mental health service structures (e.g., Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital, 1987; British Columbia's Mental Health Initiative, 1995). In 1993, a series of complaints about Riverview led to an investigation of Riverview by the Ombudsman. This investigation was the first systems review of a major psychiatric hospital in Canada. The review resulted in the report, **Listening, A Review of Riverview Hospital**, which was released in 1994. Many of its recommendations focused on how institutional services and culture needed to be changed to better address the needs of patients and family members.

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The release of the **Listening** report alongside growing international support for consumer movement and the earlier release of the Canadian Mental Health Association's **New Framework for Support for People with Serious Mental Health Problems** helped to shift mental health policy in British Columbia. That is, consumers and family members began to be recognized as significant stakeholders in mental health. The most progressive articulation of this to date is found in the BC Mental Health Plan, where the government indicates that it will work "in partnership with consumers, families and communities…to develop integrated, balanced and effective regional mental health service systems" (1998:5).

Along with these developments, in the 1980s and 90s governments have expressed concerns about increasing demands on the health care system. These concerns are being articulated at a time in which the federal government and many provincial governments have lessened their commitments to essential social services like health, education, pensions and welfare.

Mental health reform is therefore taking place in a context of fiscal constraints and cutbacks to health and social services. The federal government has indicated that it is seeking to save seven billion dollars through cuts in payments which were intended to subsidize the public services of health, education, public pensions and welfare. To accomplish this, in February, 1995, the government introduced the Canada Health and Social Transfer and repealed the Canada Assistance Plan, which has effectively eliminated national standards for the provision of health and social services by giving more control to provincial governments with respect to how they spend their health and social service dollars. Dollars for physical and mental health have been integrated, resulting in fears that current funding levels for mental health will decrease. British Columbia, however, has managed to protect mental health dollars by securing a separate funding envelope for mental health services.

Across Canada, mental health reform has taken similar forms – that is, the gradual downsizing of large psychiatric institutions and a

move to a de-centralized, region-alized mental health care delivery structure. All provinces in Canada, except for Prince Edward Island (which went back to a centralized system) have followed this general pattern, although each has its unique features. Mental health reform has also been accompanied by legislative changes to the mental health acts of many provinces, the details of which are discussed below.

While regionalization can be said, in part, to have been conceived out of fiscal constraints, it can also be seen to be potentially a more democratic and responsive structure for the delivery of mental health care services. The benefits of regionalization are its ability to bring individuals from different service sector sites and community members to the same table to establish how best to distribute regional resources. It also presents an opportunity to integrate hospital-based and community-based services under a single employer. In this respect, fiscal constraints notwithstanding, regionalization provides a prime opportunity for the full integration of women's needs and

concerns in the mental health system.

On the ground, our respondents indicated that the regionalization process in British Columbia was creating confusion for people as they struggled to understand and respond to the new structures being implemented. Service providers were particularly afraid that regionalization would mean a loss of services to their particular area; in some instances re-structuring had already had this effect. The opportunities that regionalization can present are threatened by bureaucratization and the lack of clear mechanisms for public participation and accountability structures.

A. The Mental Health Act[32]

There is a push in the US, Australia, New Zealand, the UK and Canada to expand mental health laws and grant the capability to monitor and control individuals with serious mental illnesses. All provinces across Canada have **Mental Health Acts**, except for Nova Scotia whose provisions for mental health are covered by the **Hospitals Act**. Bills to amend existing mental health acts have been introduced in several

The debates currently surrounding the amendments to the Mental Health Act in British Columbia and other provinces represent one of the most difficult human and ethical dilemmas.

provinces (British Columbia, Manitoba and Ontario). Saskatchewan is the only province with a community treatment order law and is currently the only province to implement and enforce treatment orders since July, 1995. In the U.S. nearly 40 states have passed "involuntary outpatient committal laws." In Canada and in the U.S., organizations representing family members like the Schizophrenia Society and The National Alliance for the Mentally Ill are often the biggest proponents for these changes.

On July 29, 1998, Bill 22, the **Mental Health Amendment Act**, was passed by the British Columbia Legislature. Bill 22 will be proclaimed in November 1999. Bill 22 came about largely as a result of the pressure of family caregiver lobby groups, in particular, the British Columbia Schizophrenia Society who are concerned that the existing **Mental Health Act** does not have enough authority to enforce treatment of severely mentally ill individuals. The assumption embedded in the act is that involuntary treatment of persons who are deemed to have serious

mental illnesses is sometimes necessary, and, in fact, in their best interests. The notion is that individuals who are mentally ill are sometimes unable to see their need for treatment and that because of this they suffer needlessly and can, at times, be dangerous to those around them. The stress experienced by family members in these situations is profound and the consequences for some individuals who have been refused involuntary treatment has sometimes been fatal. About 4,000 of the 30,000 British Columbians per year admitted to hospital for psychiatric reasons are involuntarily admitted (Adult Mental Health Division, 1998).

Critics of the **Mental Health Act** in British Columbia and its latest set of amendments argue that the law is paternalistic at best and at worst can be used as a tool of individual or social control.[33] The **Mental Health Amendment Act** brings several changes to the **Mental Health Act** – the most controversial of these are the rules around extended leave (in other provinces this is known as community treatment orders) and involuntary committal practices.

Women consumers should have the structure and support to organize autonomously, with the commitment to sharing their views with other mental health constituents.

Extended leave has always been in the **Mental Health Act**, but the new committal criteria will allow the Act to intervene in more cases and enforce medication compliance.

The debates currently surrounding the amendments to the **Mental Health Act** in British Columbia and other provinces represent one of the most difficult human and ethical dilemmas. Our view is that legislation should not be seen as the solution to these dilemmas. Further, in the context of fiscal constraints, there is always the concern that legislation will be seen as a "quick fix" in the absence of adequate services and support.

⤳ Recommendations

· All legislation that gives the state the ability to force treatment and involuntarily commit people, must be closely monitored and evaluated. This monitoring and evaluation must be done by an outside body with strong representation from consumer survivors.

· The system needs to demonstrate that it is changing to better meet the needs of women with serious mental health challenges and make assurances about system reform, rather than implement coercive legislation.

B. Participatory Policy-Making

In a very real way, only service users and practitioners know how policies are being implemented and understand the real effects of these policies. Unless that knowledge is included as an integral and ongoing part of the policy process, the outcomes from policy-making will inevitably fail to respond adequately to the needs of service users (Wharf, 1998:134).

Mental health reform processes must employ participatory policy-making structures to ensure that the voices of all mental health constituents, particularly the marginalized voices of women consumer survivors, are heard. Participatory policy-making should highlight differing perspectives and devise ways of working with these differences, rather than attempting to reach consensus in all instances.

Governments across Canada have come to explicitly recognize consumers and families as,

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"critical partners in planning, delivering and evaluating mental health care delivery" (Best Practices in Mental Health Reform, 1997). But how can this "partnership" be realized, especially in the context of power inequities between the participating constituents? How can barriers to women consumer survivors' participation be identified and removed so that they can equitably participate?

Currently, in British Columbia and in other Canadian jurisdictions partnership models (which bring consumer survivors, family members and service providers to the same table for input into the policy process) are being uncritically employed. Partnership models do not recognize power differences among group members. In particular, these models do not adequately recognize the impact of stigma on consumer survivors and the resulting marginalization that inhibits their full participation.

In our focus groups, the majority of women consumer survivors were unaware of opportunities that might exist for their participation in the policy-making process. Women consumer

survivor participation must be strengthened and seen as an integral component at every level of the mental health care system.

Women consumers should have the structure and support to organize autonomously, with the commitment to sharing their views with other mental health constituents. Autonomous organizing is critical to the full participation of women consumer survivors.

Rather than partnership models, alliance-building models such as that developed in Ontario by the Psychiatric Survivor Leadership Facilitation Program in 1994 (Church, 1992, 1994 & 1996) should be adopted. These models are not based strictly on consensus building but rather employ mechanisms that allow participants to examine their assumptions and biases against other group members.

Already existing committee or council structures designed to advise governments on policy can be re-structured based on the alliance model. A process also needs to be developed for hearing concerns and complaints to ensure the accountability of any advisory structures.

In addition to the above structure, each health region within a province should be encouraged to develop methods for consulting with women consumer survivors in their communities. Methods for consultation should be based on structures that are locally relevant and should be developed with the input of women consumer survivors.

Finally, in recognition that mental health concerns cross all government ministries, mental health must be on the agenda of policy makers in all sectors. Interministerial coordination is needed to ensure that the mental health consequences of all policy are understood.

C. Advocacy

Across Canada there are many organizations providing advocacy for consumer survivors and family members. In British Columbia, as part of the Mental Health Plan, a provincial advocate is now in place.

Advocates and advocacy organizations have a critical role to play in ensuring that a participatory policy structure is actualized. These organizations should take a leadership role in advocating for autonomous women consumer survivor organizations and alliance models in policy-making and service-delivery development.

As part of the mental health reform process in British Columbia a mental health advocacy framework is being developed. The framework is meant to support the implementation of the Mental Health Plan. In the development of this framework and others like it, the inclusion of groups that advocate for women consumer survivors is necessary. For example, the Canadian Mental Health Association is one organization that could take a leadership role by building on its past work on women and mental health and by dedicating a staff person to women's mental health policy issues. Additionally, feminist organizations whose work overlaps with that of the mental health system need to form better alliances with women consumer survivors and become more involved in mental health policy making structures.

VIII

Visions for the Future

The findings of our research and of many other studies on women's mental health (e.g., Jonikas, Bamberger & Laris, 1998; Women's Issues in Mental Health and Addictions Work Group, 1994; Lepischak, 1992; The Women's Mental Health Agenda Project, 1993) provide overwhelming evidence that women's and men's experiences of mental health concerns differ. Further, these and other sources provide evidence that gender is a determining factor in how women and men will be diagnosed, responded to by professionals and treated within the mental health system. In addition, as we have noted, women's mental health has become a priority for some governments. Despite this, as our research illustrates, mental health policy development and service delivery continue to be guided by gender-neutral frameworks which are universally applied to both men and women. This approach reinforces and perpetuates the gender inequalities which already exist within the mental health system. Promoting equality between women and men means actively recognizing differences and, in particular, the gendered experience of diverse groups of women.

In Canada, as in other Western, industrialized nations, the reform of public health policies is high on government agendas. In Canada, mental health reform is intimately linked to cutbacks and fiscal constraints: "while many social commentators have argued that the challenges [of policy making] should have the well-being of all citizens as their primary concern, the reality is that economic and fiscal matters take precedence in Canada" (Wharf, 1998:4). These constraints cannot be allowed to dictate policy and service provision development. Scarcity is not just a financial problem but also a moral problem of just distribution (Sevenhuijsen, 1997). Governments in Canada have increasingly pulled back from social service spending, while placating large multi-national corporations and the business sector by instituting

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major tax cuts (Wharf, 1998; McQuaig, 1995).

On the other hand, mental health reform is also linked to the rise of community mental health approaches and anti-psychiatry activism that is challenging the deeply entrenched power of the bio-medical paradigm. It is the latter development which affords the greatest opportunity for progressive mental health reform and to which we wish to contribute.

In each of our focus groups and interviews we asked our participants to imagine and describe a mental health system that was truly responsive to the needs and concerns of women. Additionally, consumer survivors were asked to describe things that had helped them become well or maintain wellness. These questions yielded a wealth of suggestions about how to improve the current mental health system as well as descriptions of innovative programs for alternative approaches. These ranged from consumer run safe houses, to holistic mental health wellness centres, to creative rehabilitation programs.

The range of responses we received reflects our view that better mental health care for women necessitates both reforms within the current system as well as the introduction of new and innovative programs which reflect a shift in how mental health challenges are understood.

With respect to the former, our vision of the future is a policy-making, service delivery structure which has integrated gender analyses at every level and is informed by the participatory policy-making and alliance-building model we have outlined. Within this model, diverse women consumer survivors and women caregivers/family members would be independently recognized as having valuable insight into the experience of mental health challenges and caregiving issues. Their experiences as women would be seen as critical to informing policy directions and service delivery.

With respect to the latter, the mental health system would be constituted by a much broader range of supports and services that would allow women choices about how best to address their particular mental health

Women consumer survivors in our study repeatedly indicated that they wanted to be viewed as whole persons.

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Critical voices like those provided by women in the anti-psychiatry movement continually challenge traditional paradigms for understanding mental health issues and expose abuses within the mental health system.

challenges. The mental health system would, therefore, draw on the expertise being developed in those jurisdictions where women-centred programs have been adopted, e.g., the work of the Elizabeth Stonehouse in the United States (Bechert, Linnell & Pope, 1991) and of other innovative housing and support projects for women such as Peggy's Place in Vancouver and Savard's House for psychiatrized women in Toronto. Women providing women-centred forms of care in other fields (e.g., violence against women) would be recognized for their particular expertise, and the transfer of knowledge between these groups and mental health workers would occur regularly.

Women consumer survivors in our study repeatedly indicated that they wanted to be viewed as whole persons. They gave many examples of how the diagnostic labeling of mental illness had affected their ability to fully participate in their support and treatment planning as well as in society at large. While not wanting to minimize the impact of serious mental health challenges, women wanted responses which emphasized their capacity for mental

wellness and allowed them the opportunity to be actively involved in deciding how best to address their needs. In our view, already existing mental health promotion frameworks could be adapted and used progressively for women-centred approaches to mental health care.

The focus in mental health promotion on the individual's social environment and on equity and social justice is consistent with the social determinants approach to mental health we are recommending. Additionally, mental health promotion is meant to foster empowerment, which is consistent with the aims of our women-centred mental health care framework.

We recommend that mental health promotion frameworks incorporate a gender analysis and the values and principles we have outlined for women-centred mental health care. With these additions, mental health promotion frameworks would be useful for guiding the development of mental health policy and programming.

Advocacy groups that specifically champion the concerns

of women mental health care consumers are necessary. The Women and Mental Health Working Group in Manitoba and The Women's Mental Health Agenda Project in Saskatchewan[34] are good examples of work of this kind. So too is the work by the Coalition for Feminist Mental Health Services, the Women's Issues in Mental Health and Addictions Work Group and Across Boundaries Mental Health Centre, all based in Toronto and working toward improving mental health services for diverse groups of women.

Critical voices like those provided by women in the anti-psychiatry movement continually challenge traditional paradigms for understanding mental health issues and expose abuses within the mental health system. These voices are important as we move toward different understandings of mental health challenges and toward more humane and holistic responses.

As our report illustrates, there is a range of perspectives and views on how best to address the needs and concerns of women with mental health challenges.

Our view is that those perspectives that actively integrate a gender analysis and that attend to women-centred values and principles are most useful in the reform of the mental health system and in the development of viable alternatives.

IX

Best Practices for Meeting the Needs of Women in the Mental Health Care System

Looking Through a Gender Lens

· A "social-psycho-bio" framework for understanding mental health, that places the first emphasis on the social determinants of mental health, should be adopted by all provincial jurisdictions.

· Gender mainstreaming and the development of a women's mental health agenda.

Women-Centred Mental Health Care

· The general principles of women-centred care, and the principles of women-centred mental health care should be used in mental health service delivery and policy development.

Caregiving

· A gender lens should be applied to any work related to understanding family support and caregiving.

Barriers

· Recognize that mental health problems exist along a continuum and ensure that the current targeting of resources to the "seriously mentally ill" does not result in discrimination against women.

· Broaden access and response to a diverse range of women.

Re-victimization in the System

· Participatory treatment models should be established that would allow psychiatrized women to have advance input into treatment planning should they be unable to make decisions during an emergency crisis.

· Establish less intrusive alternatives to the use of restraints, isolation rooms and ECT.

· Institute a zero-tolerance policy for sexual abuse.

· Women must be advised of the risks of medications.

Treatment of Choice

· Ministers of Health in each province must examine types of medical/health services that are covered or subsidized through medical service plans and take steps to include alternative and complementary therapies and counselling.

· Mental health providers must facilitate women's active participation in treatment planning.

Trauma, Violence and its Impact on Mental Health

· Train mental health workers to recognize women's responses to violence and trauma.

· Train feminist anti-violence front-line workers to provide support to women who have mental health problems and who are also experiencing violence.

· Provide support for long term counselling and peer support groups for women.

· Implement supportive training programs for mental health care consumers to help them better understand the impact of violence on women and to develop assertiveness skills to keep them safer.

Crisis Response/Emergency Services

· Put advocates/support people in place in hospitals.

· Provide confidential crisis response in every community.

Case Management/ACT

· Design ACT to be multidisciplinary and tailored to individual needs and self-identified goals.

Inpatient/Outpatient Care and Institutional Care

· Inpatient and outpatient programs, like community supports, must reflect the needs and concerns of women.

Vocational/Educational Supports

· Vocational training programs should adhere to the principles of employment equity and train women for jobs that will allow them to realize their greatest potential.

· Improve access to supportive employment and education pro-

grams. Such programs would include a focus on building self-esteem and broader social interactions. These programs would either lead to employment that would improve women's economic stability or allow women a better quality of life.

· Provide adequate income assistance to women who are unable to work.

Pregnancy, Parenting and Mental Health

· Women's roles as mothers must be recognized and supported in treatment and discharge planning.

· Provide appropriate and sensitive care to women facing custody issues.

Substance Use and Mental Health

· Establish programming that recognizes the interconnections between substance use, mental health problems and histories of physical and sexual abuse.

· Develop non-punitive policy to deal with the needs and concerns of women who have been dually diagnosed.

· Amendments to Mental Health Acts in Canada should be reviewed to ensure that criteria for committal is properly interpreted and does not discriminate against dually-diagnosed women who are mothers.

Consumer Initiatives and Peer Support

· Peer support groups should be recognized and financially supported as a necessary component of the mental health service structure.

· Provide supports that will allow consumer initiatives to succeed.

Family Support

· Recognize that the burden of caregiving falls principally to women.

· Caregivers must have access to respite and other support services such as counselling.

· Recognize the role of peer support and provide adequate financial means to implement programs.

· Acknowledge and value the multi-faceted roles of women family members and caregivers.

Diversity Issues

Women Living in Poverty and Low-Income Women

· Recognize that poverty disproportionately impacts women and their children, especially elderly, unattached women.

· Acknowledge that poverty is a systemic social problem, not a problem of individual motivation or circumstances.

· A wider range of mental health supports and treatments must be publicly funded so that all women, regardless of income, have access to them.

Women of Colour and Immigrant Women

· Develop an anti-racist holistic approach to mental health care to serve the needs of different ethnocultural communities. Existing ethnocultural organizations and support groups must be well funded and connected to the rest of the mental health system. Comprehensive strategies are needed to educate mental health care service providers on the impact of racism and settlement on mental health.

Aboriginal Women

· Recognize historical and continued abuses that lead to mental health challenges for Aboriginal women, and provide support, recognition and resources for traditional healing practices.

Older Women

· Recognize and examine further the needs of older women with mental health challenges.

Young Women

· Mental health supports specifically designed for young women are necessary.

· Service gaps that have occurred in British Columbia as a result of the re-organization of ministries must be addressed to ensure continuity of care.

Lesbian and Bisexual Women

· Respect women's sexual diversity in mental health services and planning, and provide appropriate supports to women who are exploring sexual orientation or transgender issues.

· Access to birth control and information about safe sex practices should be provided to women in psychiatric institutions and in the community.

Women with Disabilities

· Recognize the particular needs and concerns of women with disabilities who also have mental health challenges.

Criminalized Women

· In program planning, take into account the particular needs of women diagnosed with mental illnesses who have been in conflict with the law.

· Supports must allow women to access legal counsel and legal aid that is sensitive to their particular legal concerns.

Mental Health Reform

· All legislation that gives the state the ability to force treatment and involuntarily commit people must be closely monitored and evaluated.

· The system needs to demonstrate that it is changing to better meet the needs of women with serious mental health challenges and make assurances about system reform, rather than implement coercive legislation.

Participatory Policy-Making

· Women consumers should have the structure and support to organize autonomously, with the commitment to sharing their views with other mental health constituents.

· Rather than partnership models, alliance-building models which recognize power differences between different mental health constituents should be adopted.

Advocacy

· Advocates and advocacy organizations should take a leadership role in advocating for autonomous women consumer survivor organizations and alliance models in policy-making and service-delivery development.

Appendix

Focus Group Research Participant Profiles

Between 12 and 25 women participated in each consumer focus group. Although the majority of the participants were between the ages of 21-50, some groups had representation from older women and two groups included representation from adolescents. One group was comprised predominantly of women who were anti-psychiatry activists.

The majority of the participants had serious and persistent mental health problems. Psychiatric diagnoses included bi-polar and other affective responses, depression, schizophrenia, multiple personality response, dissociative identity response and in some cases anxiety and panic responses. Many of the participants also revealed physical disabilities.

Although we did not interview women who were currently in psychiatric insitutions, the majority of our participants had had a wide range of experience with these institutions, including involuntary committals. The average amount of time that women had been in contact with various parts of the mental health system ranged from one to 35 years, with most participants having been involved for 10-11 years. Many women were still actively engaged in the system, some had become well and left, while others had left in order to pursue alternative treatments. Women's experiences with forms of treatment included, for the majority of participants, some form of medication. Many other forms of treatment were mentioned throughout the focus groups including isolation rooms, physical restraints and electroconvulsive therapy. A very high number of women revealed past or present histories of physical and sexual assault, including sexual and physical abuse as children. In many instances women who were mothers had had their children apprehended, often directly as a result of their diagnosis with a mental illness.

The service providers attending each group varied from community to community with representation primarily from mental health centres, local hospitals, local community-based services such as drop-in or peer support programs, drug and alcohol programs, women-serving organizations (e.g., transition homes and sexual assault centres) and services to Aboriginal peoples. The number of service providers attending ranged from six to 15. The vast majority of service providers had extensive experience working in the mental health system. Some service providers also identified as mental health consumers or family members.

Women family members/caregivers most often attended the service provider focus group except in communities where the community developer felt it was appropriate for them to attend the consumer focus groups. In at least one of our focus groups, women family members/caregivers formed the majority of the group.

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Endnotes

[1]Revitalizing and Rebalancing British Columbia's Mental Health System: the 1998 Mental Health Plan, 1998 (referred to henceforth as the BC Mental Health Plan); The Global Alliance for Women's Health, 1997; Canadian Mental Health Association, 1987 & 1995; Federal/Provincial/Territorial Working Group on Women's Mental Health, 1993.

[2]For example, the 1998 BC Mental Health Plan and the Canadian Mental Health Association's A New Framework for Support for People with Serious Mental Health Problems, 1993.

[3]The terms used to refer to women who have chronic and persistent mental health problems vary according to who is using the terms. Mental health providers and policy makers tend to use terms such as "the seriously mentally ill", "patient," or "consumer" while those who are critical of the mental health system are more likely to use terms like "consumer survivor" or "psychiatrized women." In our report, we alternate between the various terms depending on whose voice we are representing.

[4]The BC Centre of Excellence for Women's Health is one of five centres across Canada which conducts action research on women's health policy, women's health initiatives, and women-centred programs. The Centre holds discussion groups where a broad range of service providers, community members, policy-makers and academics come together to develop action-oriented research agendas.

[5]It should be noted that one of the researchers on the project identifies as a consumer survivor and that at least eight of the 15 members of the Project Advisory Group identify as consumers.

[6]In this report we use the term "mental health system" to refer to those services and institutions which provide care and assis-

tance to individuals with mental health problems. Services which fall outside of this formal system (i.e., feminist service organizations or alternative therapies) may also provide support to women experiencing mental health challenges but are referred to separately because they generally work from non-biomedical understandings of mental health.

[7]For example, community developers who were themselves consumers were employed by the project in each region to organize the focus groups. In each consumer focus group attempts were also made to identify ways that women could continue to meet and have input into the policy process.

[8]The literature review focused on several related areas: 1) literature which critically examines the differential impact of mental illness on men and women, 2) literature which examines the impact of mental health reform on women, 3) literature which presents women-centred frameworks for service delivery and policy development and, 4) literature specific to the particular mental health concerns of women

(e.g., literature on violence and abuse, on mothering, pregnancy and mental health problems, etc.).

[9]For example, the BC Ministry of Women's Equality publication, Gender Lens: A Guide to Gender Inclusive Policy and Program Development, 1995 and the Status of Women Canada Guide, Gender-Based Analysis: A Guide for Policy Makers, 1996.

[10]Overall, the researchers spoke with more than 200 women consumers and approximately 90 individuals who either worked within the mental health system or were family members or caregivers.

[11]The researchers were not always successful in the focus groups in canvassing the views of women who do not have easy access to the mental health system, especially the views of immigrant women. In recognition of this, one focus group was dedicated to the participation of women from local Chinese communities and a number of key informant interviews were done with women from immigrant communities. Two of our focus groups were attended predominantly by Aboriginal women and at

least one of our key informants was Aboriginal.

[12]Discussion among the Project Advisory Group members resulted in a concern that some women who are traditionally unable to access mental health services might be missed by this definition. A decision was made to attempt to include some women who did not have extensive experience of the mental health system, but who had serious mental health problems. Care was taken to ensure that women who had had only minor mental health issues were not solicited.

[13]The eight fieldwork sites were all in British Columbia: Williams Lake, Chetwynd, Port Hardy, Prince Rupert, Kamloops, Duncan, Nelson and Vancouver/ Richmond.

[14]In this report we have chosen to replace the term "disorder" which medicalizes and pathologizes women, with the term "response" which reflects the recognition that many of the behaviours/symptoms that are diagnosed as mental illnesses can be understood as responses to traumatic life events. We would like to thank Sasha McInnes for suggesting this shift in language.

[15]This partnership involves the Ministry of Health and Ministry Responsible for Seniors, Ministry of Municipal Affairs and Housing, BC Housing, non-profit housing societies and the co-operative housing sector.

[16]Studies have shown that persons with mental health challenges are no more likely than other individuals in the population to be violent. See Mental Illness and Violence: Proof or Stereotype, Ottawa: Minister of Supply and Services, 1996.

[17]That is, policy that is developed through the input of the constituents that the policy will affect.

[18]Some of the principles and values here are those listed in a working document on women-centred care prepared by Jill Cory in consultation with the BC Centre of Excellence's Women-Centred Care Discussion Group.

[19]For one suggested curriculum on gender and women's issues for psychiatric residency training see Anna Speilvogel, Leah Dickstein and Gail Erlick Robinson, A

Psychiatric Residency Curriculum About Gender and Women's Issues in Academic Psychiatry, vol. 19(4) Winter, 1995.

[20]That is, feminist service providers and mental health care providers must ensure that partnerships are not used to further marginalize women consumer survivors. Instead the strengths in both systems need to be drawn on to develop women-centred mental health care.

[21]In the BC Mental Health Plan, serious mental illnesses are described as schizophrenia, manic depression and bipolar "disorder"; however, the plan also acknowledges "that there are others for whom medical risk and impairment, regardless of diagnosis, determines their mental illness as serious" (p. 92).

[22]Tardive dyskinesia is a permanent neurological deficit associated with long-term use of neuroleptic medications. It is more common in women (V/RHB Women's Health Planning Project).

[23]Alternatives were discussed at a Vancouver conference, Tough Issues: A Community Consulta-tion on Alternatives to Restraints, sponsored by the BC Coalition of People with Disabilities, June 13-14. 1999.

[24]David Cohen and David Jacobs (1998) have written a "Model Consent Form for Psychiatric Drug Treatment" which is intended to highlight the risks people enter into when consenting to take drug therapy – it stands as a useful model of a consent form that could be developed to help make women more aware of the side effects and risks of psychotropic medications.

[25]For example Jessica Jonikas and Judith Cook, Safe, Secure and Street-Smart: Empowering Women with Mental Illness to Achieve Greater Independence in the Community, National Research and Training Centre on Psychiatric Disability, Chicago, Illinois, 1993.

[26]For an example of this kind of commentary see Patricia Pearson, Giving Birth to Mad-ness, The National Post, March 9, 1999.

[27]There were concerns from some of our research participants that the impending amendments to the British Columbia **Mental Health**

Act (Bill 22) may leave scope for this law to be invoked punitively against mothers who have been psychiatrically diagnosed to force treatment.

[28]Established in 1992, the Network publishes a newsletter and runs several support groups for women. It also tries to provide consumer survivors with opportunities for alternative forms of treatment.

[29]For example, in British Columbia the "Sharing and Caring" self-help model has been supported by family groups. In the US the National Alliance for the Mentally Ill recommends their "Family to Family" program.

[30]Culture and Health 2000 is a British Columbian initiative which is attempting to ensure culturally sensitive mental health care for all people in British Columbia.

[31]In British Columbia, children and adolescent mental health is dealt with under the Ministry of Children and Families, while adult mental health is under the purview of the Ministry of Health and the Ministry Responsible for Seniors.

[32]There are other pieces of legislation that are relevant to mental health consumers (e.g., Adult Guardianship legislation and Representation Agreement Acts); however, the **Mental Health Act** overides all other legislation, which makes it particularly significant.

[33]One of the concerns is that abusive parents could force "treatment" on their children to keep them from speaking out about abuse. A Michigan researcher found that psychiatric drugs, including Ritalin and neuroleptics are being given to children under the age of three. On investigation it was found that many of these children were living in abusive homes (Sherman, 1998).

[34]The Women's Mental Health Agenda Project has designed "fact sheets" which address women's mental health issues including violence against women, the over-prescription of drugs and a pamphlet outlining women's mental health rights.

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À l'écoute des femmes

Soins en santé mentale des femmes

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