

Implementing a Woman Abuse Screening Protocol:

*Facilitating Connections between Mental Health,
Addictions and Woman Abuse*



Women's Mental Health and
Addictions Action Research Coalition

2007

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The Journey

This project to develop a woman abuse screening protocol was viable because of the pre-established collaboration and relationships between the agencies from mental health, addiction and woman abuse sectors, as well as, the workers and consumer/survivors who participate in the Women's Mental Health and Addictions Action and Research Coalition (WMHAARC). The 'Kitchen Table' research, conducted with women who had been consumers of mental health services across the province, predisposed WMHAARC members to recognize the immediate importance of expanding the Routine Universal Comprehensive Screening for woman abuse (RUCS) to the mental health and addictions sectors. The woman abuse and sexual assault agencies that were part of WMHAARC provided training and on-going support in the development of the project. The Advisory Committee, which is a sub-committee of WMHAARC, developed and implemented the screening protocol in association with those mental health and addiction agencies that participated.

This manual documents a journey of collaboration, learning and significant change in the way we respond to women who seek mental health and addiction services in our community. I have been entrusted with the responsibility to weave together the experiences and the stories of those who have made this journey. It is an honour.

Barb MacQuarrie

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Introduction

This manual is intended to provide guidelines on how to assist abused women to create safety through screening for woman abuse and woman abuse-related trauma and through responding appropriately to disclosures of abuse. It is specifically for frontline and management staff from the mental health and addictions sectors.

The authors recognize the inherent challenges in achieving an effective integrated response to clients screened for abuse. The team that has overseen the implementation of the Woman Abuse Screening Protocol, works in the mental health, addictions and woman abuse sectors. Ongoing collaboration between the three sectors has provided the foundation for the project and was essential to the successful implementation of screening. Participation in the development of the screening protocol has resulted in a better understanding of how to work together more effectively. Documenting what been learned has allowed for the design of a tool that can be shared amongst other helping professionals in order to create systemic change.

It is hoped that the manual will be used as a blueprint within other areas of the province, both urban and rural, to accomplish successful implementation of screening protocols for woman abuse and abuse-related trauma in the mental health and addiction sectors. The information presented will help to prepare agencies for the impact of community mental health and addiction staff acknowledging woman abuse and abuse-related trauma in their practice. It will provide a conceptual framework for understanding the role of the mental health professional in addressing woman abuse and first stage trauma with clients. The manual also provides accessible information to staff on standardized components of appropriate responses and referrals (e.g. short-term safety planning) and specific tools and strategies to use in beginning this work with a client who discloses abuse.

Acknowledging woman abuse and abuse-related trauma experiences and coping strategies recognizes that the challenges experienced by clients are related to the abuse they survived. This helps women to reframe their perspectives on negative symptoms as understandable adaptations and self-protective behaviours. Recognizing woman abuse and abuse-related trauma also encourages women to consider referrals to appropriate support services.

In the community of London-Middlesex, one of the agency partners in the addictions field reported that 80 per cent of the women screened at assessment for a six-month period disclosed abuse during the implementation of the Screening Protocol for Abused Women. Of these, 13 per cent required safety planning at the time of the disclosure. Another partner agency providing crisis mental health services reported that of those female clients screened, 73 per cent reported childhood sexual abuse and two per cent reported current sexual abuse. Many of these women also reported continued contact with their abuser.

Specific training initiatives are required before an agency implements protocol for woman abuse and abuse-related screening. Suggestions and outlines for those trainings

are included in this manual. It is important to recognize the need for a supervision structure to address the vicarious trauma and abuse related-trauma staff will encounter as a result of the increase in the number of woman abuse disclosures.

Building stronger linkages between the mental health, addictions and woman abuse sectors will create better service provision for clients, provide more opportunities for consultations, and will help abused women who often can't access service for reasons related to their safety to receive appropriate support.

The introduction of the protocol to screen for woman abuse has achieved the following objectives in the community of London-Middlesex:

For the client:

- Facilitated access to services that will provide appropriate treatment and support for woman abuse and abuse-related trauma.
- Improved support from current mental health and/or addiction workers.

For the staff:

- Improved identification of women who have been abused or are being abused in their lives.
- Increased recognition of woman abuse and abuse-related trauma and the impact it has on health.
- Improved linkages, relations and awareness of woman abuse/abuse-related trauma services.
- Increased skill competency to effectively respond to and support abused women to whom they are providing service.

For the system:

- Improved data on the number of women in mental health and addiction services that experience woman abuse and abuse-related trauma in their lives.
- Supporting documentation to effect increased availability of woman abuse and abuse-related trauma services for woman with serious mental illness and/or substance abuse issues.

The single most important factor in the success of this project has been the long standing and on-going relationships that have been developed and that continue to nurture. As stated in the introduction of *Asking Women About Abuse and Responding to Abuse Disclosure: A Guide for Addictions and Mental Health Professionals* (http://www.wmhaarc.ca/assets/Guide_to_Screening_Aug06.pdf , included with this manual)

The work of this project is grounded in the ideas of relational-cultural theory (RCT), a revolutionary approach to understanding psychological development that incorporates a gendered analysis. The efforts to build connections across sectors, asking women about abuse, and responding to disclosures are relational.

The core ideas of RCT suggest that all growth occurs in connection, that all people yearn for connection and that growth fostering relationships are created through mutual empathy and mutual empowerment.

Relational-cultural theory is rooted in the groundbreaking work of Jean Baker Miller, who proposed a new understanding of women's development in her book, Toward a New Psychology of Women (Miller, 1976). This book and other resources about RCT can be ordered from the Wellesley Centres for Women at <http://www.wcwoonline.org/index.html>.

In addition to documenting the process that was followed to implement woman abuse screening in mental health and addictions agencies, a significant amount of contextual information has been provided. Chapters seven to nine are the core of this manual, where a step-by-step description of what was accomplished is provided. These chapters are intended to serve as an implementation guide.

What Do We Know About the Connections Between Mental Health, Addictions and Woman Abuse?

Researchers in the fields of mental health and addictions are increasingly drawing the links between issues associated with substance use and mental health. As a result some researchers are recommending screening clients for both sets of issues. Gamble and Ayim report,

In recent years, research has shown a high prevalence of co-occurring substance use problems in people being treated for mental health concerns and a high prevalence of mental health problems in clients with substance use issues. In Ontario, for example, concurrent substance use problems are believed to range from 15 to 45 per cent in people receiving mental health services, and concurrent mental health problems are thought to range from 75 to 100 per cent in those receiving substance use services. As a consequence, all agencies in the substance use and mental health systems should screen for both mental health and substance use problems. (*Navigating Screening Options for Concurrent Disorders*, CAMH, 2006)

On their website, The Centre for Addictions and Mental Health cites data from a recent Canadian population survey showing:

- 16.1 percent of people diagnosed with any mental disorder during their lifetime experienced a substance problem some time in the preceding year
- 27.5 per cent of those identified with a current alcohol problem will also have a mental illness at some point in their lifetime
- 38.3 per cent of those with a current substance use problem, other than an alcohol problem will also have a mental health disorder at some point in their lifetime
- The risk of mental illness increased with the severity of the substance use disorder (for instance, people with substance problems were at twice the risk of meeting the criteria for lifetime mental illness, whereas people with substance dependence were at four times the risk of meeting the criteria for lifetime mental illness).

([www.camh.net/About Addiction Mental Health/Concurrent Disorders/index.html](http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html))

Although somewhat more tenuously, research is also beginning to link mental health and substance abuse problems to trauma. CAMH acknowledges that, “For some people, a common factor may lead to both mental health and substance use problems. This factor may be biological. It may also be an event, such as emotional or physical trauma.”
([www.camh.net/About Addiction Mental Health/Concurrent Disorders/index.html](http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html))

Gamble and Ayim echo this perspective, noting that,

A history of trauma, and the persistence of symptoms related to the trauma, is also very common among clients with mental health or substance use issues. About 25 to 66 per cent of people in substance use treatment will have histories of trauma, though not all people who have experienced trauma will develop symptoms of posttraumatic stress disorder. Among women, the experience of physical and/or sexual violence, mental health problems and substance use problems is a significant issue. (CAMH, 2006)

WMHAARC's participatory action research has demonstrated a very significant connection between mental health, addiction issues and woman abuse and woman abuse-related trauma. A 2002 study of women involved with the mental health system found that 80 per cent of participants spoke of either childhood abuse and/or violence in their current relationships. This led the researcher to conclude that reactions to woman abuse and abuse-related trauma are often used as signifiers of mental illness. The 75 women involved in the study came from diverse backgrounds throughout the Province of Ontario including rural, urban and northern communities (63), recent immigrants or refugees (7) (lived in Canada for less than 12 years), and those who identified as lesbian, bisexual and/or transgendered (5). (<http://www.wmhaarc.ca/assets/KitchenTableProject.doc>)

Woman abuse and woman abuse-related trauma survivors speak eloquently of the devastating consequences when professionals do not understand the links between mental health and addictions issues and woman abuse and woman abuse-related trauma. One of the women who participated in our 2002 research explains,

I entered the mental health system because I was overwhelmed by memories of abuse. And this was not understood. I was treated with drugs when what I needed was a listening ear. I was placed on a co-ed ward where I was followed by one man who wanted a relationship with me. I got into trouble when I could not sleep at night because of the nightmares. I went into the mental health system seeking refuge and a space to deal with the abuse I had experienced at the hands of my family and my partner. I came out of the mental health system having to deal with the abuse I received within the system. I ask you – do you think that was helpful?" (<http://www.wmhaarc.ca/assets/KitchenTableProject.doc>)

It is vitally important to the lives of women who have survived woman abuse and woman abuse-related trauma that service providers understand the connections between mental health issues, addictions and woman abuse and abuse-related trauma. Otherwise, as the 2002 research found, both the stigma and labeling with mental illness leads many women to label themselves as mentally ill. This label then becomes the main source of self-identity and as such affects self-esteem, social interactions and involvement in activities outside of the mental health system. The result is the hopelessness and despair you hear in the voice of this woman,

I have been labeled with six or seven different things. And I often ask myself 'Who am I?' All I know is that I am a nut. No wonder people do not want me in their lives." (<http://www.wmhaarc.ca/assets/KitchenTableProject.doc>)

Another compelling voice on the subject is Dr. Dusty Miller, an incest survivor, a clinical psychologist, writer and consultant specializing in trauma and addictions, loss, and recovery from illness. She tells her own story to illustrate how drawing the connections between addictions, mental health diagnoses and trauma facilitated her own healing:

I don't know what diagnoses I'd been given by my well-intentioned New Haven psychologist, Dr. M., who'd minimized my alcoholism and repeatedly told me that my memories of incest were fantasies representing my disguised yearning for my father. But I suspect my bulging file contained references to borderline personality disorder or depression with psychotic features. Like thousands of other traumatically abused and misdiagnosed women, I was well on my way to developing the "spoiled identity" of a chronic mental patient. Dr. M. had led me to believe that I'd spend the rest of my life in and out of psychiatric units like the one I then found myself in at Waterbury.

Once I stopped abusing drugs and alcohol, my flashbacks and dissociated states lessened markedly. With my friends' encouragement, I weaned myself from the overpowering antipsychotic medications that had kept me groggy and debilitated. I'd given up the spoiled identity of the mental patient in favor of the more accurate—and therefore more helpful—label of the recovering addict and alcoholic.

After nearly a century in which the mental health field had dismissed reports like mine as fantasies, we victims lost patience with being spoken about and began to speak for ourselves. If our culture wanted to play Non-Protecting Bystander, we'd strip away the collective ignorance that had served as its shield. Like gay people and people of color before us, we defiantly embraced and began to dismantle the spoiled identity we'd been assigned. Oprah Winfrey, Maya Angelou, former U.S. Senator Paula Hawkins, and former Miss America Marilyn Van Derbur all said on television that they'd been sexually abused as children. By becoming vocal, we challenged the family and cultural role we'd been assigned: to suffer in silence, save everyone else from discomfort, and internalize the damage.

In the face of the carefree old public narrative—that incest was either imagined or consensual, and in any case, only occurred in one in a million families—we faced what lay in plain sight: that child sexual and physical abuse were real, damaging, and prevalent; and so were rape and other forms of family violence. If childhood and family trauma could be stopped and effectively treated, we figured, whole categories of the DSM—borderline personality disorder, dissociative disorders, substance abuse, cutting, sex addiction, other behavioral addictions, PTSD, and even some forms of anxiety and depression—might practically disappear.
<http://www.dustymiller.org/Articles.htm>

History of the Project

Where it all Began: The Women's Mental Health and Addition Action and Research Coalition

The Screening Protocol for Abused Women is a project of the Women's Mental Health and Addition Action and Research Coalition (WMHAARC), based in London, Ontario. WMHAARC has worked since 1999 to improve the quality of life for women within the mental health, addictions and violence against women sectors, to increase public awareness of women's needs and to advocate for systemic changes on all levels of service delivery. With more than 80 members, WMHAARC is a coalition of women who use mental health and addiction services, service providers and representatives of community organizations. Dedicated to action oriented, community based research; WMHAARC has been involved in a series of projects which have culminated in the development of the Screening Protocol for Abused Women.

Participatory Action Research

Participatory Action Research (PAR) has driven the work of WMHAARC and informed the development of the Screening Protocol for Abused Women. PAR was an appropriate research methodology for this work as it assumes that researchers need to work with the community to determine what community members need to know from the project; that reciprocity and collaboration are easier when the community treats research as a venue for reflection, advocacy and action rather than simply as an academic endeavor. Researchers openly discuss how differences in power and position may affect the collaboration and what the researcher writes should be understandable and useful to the community.

Two research reports, "*Barriers to the Implementation of Gender Sensitive Policy and Principles of Service in Ontario's Mental Health System (Phase 1)*," released in July 2001, and "*Kitchen Table Talks: Evaluating the Experiences of Women within the Mental Health System Since Reform (Phase 2)*," released in July 2002, provided the background information and motivation to develop the Screening Protocol for Abused Women. The findings from these reports are summarized below.

The project, *Barriers to the Implementation of Gender Sensitive Policies and Principles of Service in Ontario's Mental Health System* was conducted at a time when there was a growing awareness of the need to apply a gendered analysis to the last decade of mental health reform strategies. Eighty-two community mental health centres were surveyed. Questions were developed by a focus group of front line workers and survivors/consumers about current policies and principles, the openness of the organization to implement gender sensitive policies and principles and the movement of the organization to do so.

The report's findings revealed a long list of barriers including,

- insufficient funding;
- an emphasis on generic service delivery;

- a medical model of service delivery;
- the lack of concrete examples of gender-sensitive policies and principles;
- confusion about the term gender sensitive;
- an under participation of women survivors/consumers in defining healing process and programs; and
- geographic isolation.

For the full report, please go to

http://www.wmhaarc.ca/assets/Barriers_to_Implementation.doc.

The next report, *“The Kitchen Table Project: Evaluating the Experiences of Women within the Mental Health System Since Reform,”* examined how successful mental health reform had been at providing specialized services, a heightened voice for the consumer and gender sensitive programs, principles and policies in the mental health system. The purpose of the research was to hear women’s voices from a collective and province wide perspective, to assess the effectiveness of services and resources for these women, to assess the environment in which services were being offered, and to assess the need for women specific services.

Seventy-five women participated in focus groups and interviews. The women represented varied demographics with 20 per cent from rural northern communities, 33 per cent from southern rural communities, 22 per cent from urban northern communities, 5 per cent from urban southern communities, 9 per cent from multicultural communities and 9 per cent were lesbian/bisexual/ transgendered.

Thirteen focus groups were conducted with three to six participants in each. They were led by two trained survivor/consumers and supervised by a front line worker at a local agency. All questions were developed by the focus group facilitators via teleconferences. Child care and translation services were provided. The groups were three hours in length and were tape recorded and later transcribed. Twelve individual interviews were conducted with women who felt at risk attending focus groups.

Women reported the following concerns about the mental health system:

- Inadequate and insufficient services for women especially in isolated communities.
- Women shifted through many services before finding one that works for them.
- Family doctors are a key source of support.
- Women have a holistic view of mental health that is largely unsupported.
- Women are often treated by medications alone.
- To receive good services women have to be assertive.
- Many psychiatrists do not meet the needs of female clients.
- Poverty, stigma, isolation and lack of information serve as barriers to service.
- The use of labels perpetuates myths and stigma.
- Women who use the mental health system have often suffered abuse as a child or adult.

- Women often do not feel believed, listened to, taken seriously or supported in the mental health system.
- Mental health reform has negatively impacted on the services women receive.

Findings from this research indicate that few agencies had gender-specific policies, principles and services, agencies did not feel supported to develop these and the burden is on the consumer to seek and obtain appropriate services. Findings also revealed that women in the mental health system are oppressed by a multitude of factors including being marginalized by intersecting identities, women-specific concerns, poverty, transportation, family, stigma, and medicinal therapy that uses drugs tested on men.

For the full report please go to <http://www.wmhaarc.ca/assets/KitchenTableProject.doc>.

Participatory action research was used throughout the implementation of the Screening Protocol for Abused Women to evaluate progress and to gather input and feedback from those who would be impacted by the implementation; service providers, abused women and administrators. This manual describes how these tools were used and provides samples in the appendices.

Routine Universal Comprehensive Screening Tool (RUCS)

In 2002 the Ontario Trillium Foundation provided funding to pilot and evaluate the implementation of the Routine Universal Comprehensive Screening Protocol tool with the mental health and addiction Sectors in London and Middlesex. Developed by a task force of the Middlesex-London Health Unit, the RUCS Protocol is used to screen women over the age of 12 for any form of physical, sexual or emotional abuse occurring in childhood, adolescence or adulthood. The Middlesex-London Health Unit Task Force has pioneered the protocol and begun to implement it in other health divisions across the province.

The full report of the *Task Force on the Health Effects of Woman Abuse* is available at, <http://www.theinquiry.ca/Task%20Force%20Woman%20Abuse%20Marion%20Boyd.pdf>

The Screening Protocol for Abused Women is an adaptation of the RUCS tool to fit the best practice models currently used by community-based mental health and addiction services. This project is unique in that it is creating a systems response that brings together community workers from the mental health, addictions, violence against women and trauma sectors to better equip service providers to recognize the effects of woman abuse and abuse-related trauma.

Partnerships

The agencies within London and Middlesex County that agreed to participate are listed below. Women's Mental Health Resources was an independent agency when work began, but was amalgamated with WOTCH during the time the project was implemented.

- Addictions Services of Thames Valley
 - Problem Gambling Program, Substance Abuse Program & Heartspace

- Canadian Mental Health Association, London-Middlesex
 - Information/Referral, Intake/Assessment & Community Support Program
- London Mental Health Crisis Service
 - Face-to-Face & Hospital Satellite
- WOTCH
 - Langarth Housing Project, Community Support Program, WOTCH Centre & Treatment Services (PICC House & Transitional Housing)
- SEARCH Community Mental Health Association
 - Intake, Community Support Program, Community Counselling Program & Recreation Centre
- Women's Mental Health Resources
 - Community Support Program, Groups & Langarth Housing Project
- Mission Services
 - Women's Crash Beds, Streetscape & Rotholme

By selecting this cross-section of services, the relative success of implementing the protocol in various locals, client populations, and program types was assessed.

Collaborative Agreement

In July 2002 the partners signed a collaborative agreement to:

- Pilot the implementation of the Routine Universal Comprehensive Screening Protocol (RUCS) into the mental health and addiction services setting.
- Seek funding for the project
- Assess and evaluate the relative success of the implementation of the protocol in various locals, clients populations, and program types

The agreement outlined that the operation of the project will be under the direction of the Woman Abuse Screening Protocol Implementation Committee consisting of a representative from each of the partner agencies. Decisions making would be through a solution oriented consensus-building process.

Before delving into the specifics of how the Woman Abuse Screening Abuse Protocol was implemented in our community, it is important to discuss what is meant by woman abuse and explore the question, "Why Screen for Woman Abuse?"

Woman Abuse

Statistics

Woman abuse is a wide spread phenomenon in our society. On the basis of a Canada wide study in 1993, 29 per cent of women reported being physically and/or sexually assaulted by partners (Violence Against Women Survey, Statistics Canada, 1993) Many women also reported living with issues associated with unresolved child abuse. In 1999, the McCreary Adolescent Health Survey found that 35 per cent of girls between grades seven and twelve had been sexually and/or physically abused. In Canada in 2001, 69 men killed their current or ex-wives.

The Fourth Annual Report of the Domestic Violence Death Review Committee from the Office of the Chief Coroner for the Province of Ontario reported that 99 women and 9 children were murdered in 113 incidents between 2002 and 2005. Consistent with past DVDRC reports and research, the most common risk factor involved with a domestic homicide case is an actual or pending separation. Perpetrators commonly become more controlling of their partners when facing a pending or actual separation. A history of domestic violence is the second most common risk factor associated with perpetrators of domestic homicide, followed by non-diagnosed reports of depression, escalation of violence, and obsessive behaviour.

Why Do Men Abuse Women?

The answer to the question ‘why do men abuse women in intimate relationships?’ is complex. In general terms, men abuse women because of women’s inequality in society. The issue is one of power and control, where abusive men utilize a number of tactics to gain and maintain control over a woman. Specifically, these are important points to remember:

- woman abuse is a societal issue not an individual problem;
- there is no evidence that alcohol or mental illness causes woman abuse;
- violence and abuse against women is a chosen act against a chosen victim;
- woman abuse is a learned behaviour;
- abuse does not occur because of an individual’s personality;
- while some abusers may have do not all have borderline, or narcissistic or other personality disorders, this does not cause the abuse; Personality or other disorders of individual abusers cannot explain the widespread issue of woman abuse;
- violence and abuse against women occurs because society, in many ways, reinforces the belief that some individuals and groups have the right to control and have power over women;
- many men in today’s society continue to believe they have the right to control the women with whom they are in a relationship;
- violence and abuse against women has evolved in part from a system of gender relations which posits that men are superior to women;
- woman abuse is supported by the idea of male dominance, even male ownership of women, which is present in most societies and reflected in laws and customs.

Societal Dynamics

Violence and abuse against women is the consequence of the social, economic and political oppression of women within the institutions of society. A training developed by the Ontario Ministry of Community and Social Services in 2000 for staff of Children's Aid Societies and the violence against women sector provides the following examples of institutional behaviours and responses that contribute to the problem of woman abuse:

- gender bias in the legal system;
- lack of accessible resources;
- disbelief of abuse by professionals;
- treatment of abuse as a medical illness;
- racial bias among services;
- inadequate educational and economic opportunities for women;
- failure of the justice system to issue appropriate sentences which hold the perpetrator accountable.

Abused Women Overrepresented in Mental Health Services

Eighty-three per cent of female psychiatric in-patients reported being physically and sexually abused by a male partner in a study by T. Firsten, *An Exploration of the Role of Physical and Sexual Abuse for Psychiatrically Institutionalized Women*, cited by the Ontario Women's Directorate, 1990.

There are several reasons why abused women may be overrepresented in mental health and addiction services. Their abuse may result in addiction, depression, dissociation, suicidal ideation, diagnoses of PTSD and dissociative disorders, etc. They may have been misdiagnosed; the symptoms resulting from the impact of abuse (e.g. post-traumatic stress) are sometimes diagnosed as personality disorder, etc. Some women who have experienced abuse use drugs to cope or to numb out as a survival skill. Women's addictions or mental health issues may increase their vulnerability to abuse by having their mental health issues and addictions used by the abuser as a tactic to control, manipulate or intimidate them.

The Middlesex-London Health Unit (MLHU) has provided an overview description of woman abuse. It is reproduced below, with a few additions. Copies of the article can be obtained from the MLHU website at <http://www.healthunit.com/article.aspx?ID=10713>.

Definition

Woman abuse is the intentional and regular use of tactics to establish and maintain power and control over the thoughts, beliefs and behaviour of a woman by creating fear and/or dependency. All forms of abuse result in the woman losing some if not all dignity, control, safety and personal power. Abused women change their behaviour, preferences and/or choices because they fear the consequences or retaliation of their abusive partner.

Dynamics of Woman Abuse

Abuse against women occurs in families of all socioeconomic, educational and cultural backgrounds and is found in both rural and urban settings. The perpetrators of woman abuse are individuals with whom the women either have or have had intimate personal relationships. Women in lesbian relationships can also be at risk for abuse. Abuse can be shown in many ways, but most frequently it involves a repeated, escalating pattern of behaviour. Typically, abuse escalates in frequency and/or severity and once abusers use physical violence, they are likely to intensify their assaults and increase the woman's risk of harm and serious life-threatening injury. No one form of abuse is worse than the others. For example, other forms of abuse are as harmful to women as physical abuse.

Tactics of control can begin to appear very slowly as coercive behaviours that may not be criminal in nature. This subtle process makes it very difficult for the woman, as well as friends, family or professionals to recognize it as abuse. Many women identify the emotional and psychological consequences of abuse as more damaging than the physical assaults. While emotional abuse can occur in the absence of physical abuse, the two occur together in the majority of cases.

Abusive behaviour does not result from individual, personal or moral deficits, diseases, diminished intellect, addiction, mental illness, poverty, the other person's behaviour or external events. Perpetrators act from a set of beliefs and attitudes about how men and women should relate in intimate relationships. They generally believe that they have the right to enforce their will on the female partners. The abuser's choice to use any form of abuse is completely independent of the actions of the victim.

Types of Woman Abuse

Environmental Abuse

Any tactics used that result in a woman being fearful of her surroundings. e.g., slamming doors, punching walls, harming pets, driving too fast

Physical Abuse

Any unnecessary/unwanted physical contact caused by another person resulting in bodily harm, discomfort and/or injury. e.g., slapping, kicking, restraining, choking, restricting food.

Psychological/Emotional Abuse

Any act that provokes fear, diminishes the individual's dignity or self-worth, and/or intentionally inflicts psychological trauma on another person. e.g., yelling, intimidating, silence, playing on emotions, degradation, treating her as though she was a child, coming home drunk or stoned, refusing to provide support or help out with the baby/children.

Sexual Abuse

Any unwelcome or forced sexual activities. e.g., unwanted sexual contact, forces her to have sex, forcing her to have sex with others, uttering threats to obtain sex, forcing sex when she is sick, after childbirth or surgery, treating her as a sex object, refusing to allow or forcing her to use contraception

Verbal Abuse

The use of negative comments that are unwelcome, embarrassing, offensive, threatening and/or degrading to a woman. e.g. name calling, false accusations, lying, saying one thing and meaning another.

Financial Abuse

Any behaviours that reduce/eliminate a woman's financial independence and/or financial decision-making. e.g. taking her money, forging her name, withholding money, spending money on addiction, gambling, sexual services, keeping family finances a secret.

Social Abuse

Any behaviour resulting in the isolation and alienation of a woman from friends or family. e.g. controlling what she does, whom she sees and talks to, failing to pass on messages, treating her like a servant, making a "scene" in public.

Religious Abuse

Any tactics that exert power and control over a woman's spirituality and religious orientation. e.g. using religion to justify abuse or dominance, using church position to pressure for sex or favours.

Using Children

The use of threats or actions to harm the children or to take the children from her in order to control what she does, making her feel guilty about the children, using the children to relay messages

Using Privilege/Social Status

Any comments or actions that suggest she is inferior because she comes from a different socio-economic background, the use of social status or wealth to hide or deny abusive behaviour, the use of wealth to involve her in expensive legal proceedings or to manipulate or prolong legal proceedings.

Woman Abuse as Control

All forms of abuse are attempts to control. Traditional attitudes and the hierarchical structuring of society have supported the dominance of the male and the subservience of the female. Anger and aggressiveness are considered appropriate ways to resolve conflict, particularly for men. Social and legal traditions have also allowed woman abuse to be treated as a private matter within the family home. These traditions combined with the effects of the abuse may cause an abused woman to:

- believe she provoked her partner's abuse and that she did something to deserve it;
- believe that if she changes what she does or says, her partner will stop the abuse;
- feel guilty about the violence and abuse;
- deny the full extent of terror and anger that she feels;
- be very concerned with trying to keep the family together;
- be ashamed of her injuries and try to hide the fact that there is abuse is happening in her home;

- believe that the abuse happens only to her and to no one else;
- believe that no one can help her;
- underestimate her ability to do things, believing that she cannot take care of herself;
- demonstrate incredible endurance in surviving.

Health Effects of Woman Abuse

Forty-five per cent of woman abuse results in physical injury. The psychological effects of this can be far-reaching: eighty-five per cent of abused women indicate that they have experienced some type of negative emotional effects including anger, fear, becoming less trusting, suffering from lowered self-esteem, depression, anxiety, shame and guilt. In order to combat these effects, twenty-five per cent of these women report having used alcohol, drugs or medication.

Physical Health Effects Include:

- broken bones
- burns
- stab wounds
- concussions
- perforated ear drums
- loss of hair
- chronic stomach/bowel pain or discomfort
- chronic joint or muscle pain
- palpitations
- firearm wounds
- bruises
- cuts/abrasions
- bites
- sprains
- chipped or lost teeth
- internal injuries
- chronic headache
- high blood pressure
- detached retina
- substance abuse issues

Sexual Health Effects Include:

- sexually transmitted diseases
- chronic genital or pelvic pain
- bruising or tearing of the vagina or anus
- frequent pregnancies
- fear of sexual intimacy
- miscarriages
- chronic vaginal or urinary track infections
- female genital mutilation

- painful intercourse
- infertility

Psychological Health Effects Include:

- low self esteem
- difficulty in forming/maintaining relationships
- anxiety
- lack of appropriate boundaries
- self degradation
- chronic stress
- uncontrolled or rapid anger response
- memory loss
- loss of concentration or productivity
- self-abusive behaviour
- problems with parenting children
- frequent crying
- passivity
- unusual fear response
- increased watchfulness
- sleep disturbances
- phobias

Psychiatric Health Effects Include:

- depression
- eating disorders
- obsessive compulsive disorder
- suicidal thoughts
- post-traumatic stress disorder
- dissociation

This list of health effects is from the Final Report of the *Task Force on the Health Effects of Woman Abuse*, 2000.

Accessing Resources

Abused women face multiple barriers in trying to cope with the problem of abuse, either when trying to decide whether to disclose the abuse, making the decision to leave, or when accessing services for herself or her family.

Abused women identify many reasons for not disclosing their experiences to their families, friends or professionals. These reasons could include: a need for privacy, isolation, a lack of knowledge about agencies, difficulties with agencies due to prior negative experiences, cost, consequences of approaching an agency (e.g. fear of losing children), not wanting to have charges laid against the partner, hoping things will get better and fearing that her partner will find out about the disclosure and inflict punishment. A woman may feel unable to disclose the abuse for fear of not being understood, for fear of not being taken seriously, or for fear of being blamed for the

abuse. Women report that they are not often asked about abuse by professionals and that they would be more likely to report if asked.

Society has traditionally placed the accountability for abuse on the victim rather than on the abuser. Many options might not be available to women because of their socio-economic status, ethnicity, sexual orientation, age, religious affiliation, physical and mental disabilities, immigration status, education, employment status and marital status.

It is essential that family, friends and professionals understand the complexities of woman abuse and are clear that the abuse is not the woman's fault. In order for women to be able to disclose and confront the abuse, there must be trust, genuine caring and an openness that will be present as they prepare to address the abuse.

See Appendix I for a copy of the Power and Control Wheel, a tool that has been used in the violence against women sector for many years to help explain the various tactics of abuse. (www.lawc.on.ca) The National Centre on Domestic and Sexual Violence has gathered 34 adaptations of the Wheel. You can access these on their website at http://www.ncdsv.org/publications_wheel.html.

Screening

Approaches to Screening

There are four approaches to screening. Sometimes several of these approaches can be combined.

Indicator-Based Diagnosis means that a helping professional notices one or more indicators that a woman may have been abused and, referring to the indicator(s), asks the woman whether abuse has caused that injury or condition.

Routine Screening means that screening is done on a *regular* basis, i.e., once per year, when women come in contact with helping professionals, whether or not indicators of abuse are recognized.

Comprehensive Screening means that women are asked by helping professionals whether they have experienced or are currently experiencing *any* form of physical, sexual and/or emotional abuse as children, adolescents or adults.

Universal Screening means that *every* woman over an agreed upon age is asked about her current or past experience of abuse by the helping professionals with whom she comes in contact.

Recommendations for Screening

There is a lack of consensus concerning universal versus indicator-based screening for abused woman by health care providers. This controversy is not relevant to the mental health and addictions sectors because mental health issues and/or addictions are recognized as potential indicators of woman abuse.

The Task Force on the Health Effects of Woman Abuse: Final Report, (Sept. 2000) made the following recommendations regarding woman abuse screening:

- all health service providers should screen for abuse;
- screening should occur at: emergency room or urgent care examinations, referral for admission to long term care facilities or home care, general or annual examinations and on admission to or discharge from hospital;
- at minimum professionals need the following training to screen for woman abuse:
 - education about the dynamics and health effects of woman abuse,
 - establish the safety and autonomy of abused women as the priority,
 - practice cultural competency,
 - training about how to ask about abuse and how to address the abuse disclosure(s),
 - knowledge as to how to properly document the disclosure(s) on the woman's file.

The Registered Nurses Association of Ontario (RNAO) has also recommended screening for woman abuse in a Nursing Best Practice Guideline, issued in March 2005.

(http://www.rnao.org/bestpractices/PDF/BPG_Women_Abuse.pdf) The guidelines make the following practice and education recommendations:

- nurses implement routine universal screening for woman abuse in all health care settings;
- routine universal screening be implemented for all females 12 years of age and older;
- nurses develop skills to foster an environment that facilitates disclosure;
- this necessitates that nurses know:
 - how to ask the question; and
 - how to respond.
- nurses develop screening strategies and initial responses that respond to the needs of all women taking into account differences based on race, ethnicity, class, religious/spiritual beliefs, age, ability or sexual orientation;
- nurses use reflective practice to examine how their own beliefs, values, and experiences influence the practice of screening;
- nurses know what to document when screening for and responding to abuse;
- nurses know their legal obligations when a disclosure of abuse is made;
- mandatory educational programs in the workplace be designed to:
 - increase nurses' knowledge and skills; and
 - foster awareness and sensitivity about woman abuse.
- all nursing curricula incorporate content on woman abuse in a systematic manner.

Purpose of Screening

Screening is conducted in order to identify any abuse experienced by the woman, either in the past or in the present, so that this history can inform any health care/counselling interventions she may seek. Screening can decrease the incidence and prevalence of woman abuse by ensuring that mental health and addiction workers and community support services identify and respond appropriately to cases of woman abuse with effective treatment, documentation, safety measures and referrals. Through effective screening practices women who have experienced abuse or who are currently experiencing abuse can receive helpful interventions much earlier than if they had never been screened.

Preconditions to Implementing A Woman Abuse Screening Protocol

Before woman abuse screening is implemented, it is important that some preconditions are met. Staff at all levels of the organization, both front-line and management must be convinced of the utility and importance of screening. The effort to implement screening needs to be coordinated and representatives delegated to lead their team or area in the process. Staff need to understand that screening is a process that requires relational skills, not merely another task to complete.

The organization needs to work with a screening protocol that acts as a road map of actions to guide practice and to ensure no steps are missed. The protocol is also a decision-making tree. While it is important to respect the privacy and confidentiality of a woman, it is important that staff understand when it becomes legally necessary to report

disclosures of abuse and that they are able to convey that information to women being screened.

Before screening is implemented it is necessary to address staff needs. In the recommendations reviewed above, both the Task Force on the Health Effects of Woman Abuse and the RNAO emphasize the importance of education for staff. Staff need to be knowledgeable about woman abuse and they need to develop a comfort level for discussing abuse. A supervision structure for addressing the vicarious trauma that may result from hearing an increased number of abuse disclosures is needed. The application of a screening protocol will vary according to the situation and the team member asking the question.

Limits to Screening

All women who access mental health and/or addictions services should be routinely screened for abuse. Asking the question about abuse does not mean that a helping professional needs to start practicing exploratory or uncovering work. Once a disclosure of abuse happens, the focus is on safety and first-stage trauma response. This includes the use of coping skills (grounding techniques), development of a safety plan, education and referral to appropriate woman abuse and abuse related-trauma agencies and services.

First-Stage Woman Abuse-Related Trauma Response

What Is Woman Abuse-Related Trauma?

Abuse-related trauma develops after a woman has been hurt and/or neglected, often in childhood. Abuse can be sexual, emotional/verbal, physical, financial, intergenerational or institutional in nature or it can be a result of war. Most often the abuser was or is a family member, a family friend or an intimate partner.

The results of abuse can include overwhelming feelings of distress, fear and helplessness. The body reacts in a number of ways and traumatic events can change the way a woman's brain and body work. Trauma can affect a woman's emotions, memory, thinking and sense of self, and it can affect her relationships with others. It is common for women not to connect their experiences of trauma to the difficulties they are having in their day-to-day lives.

The first-stage response to trauma is dedicated to reducing and stabilizing women's responses to trauma in order to improve the quality of their everyday life. The role of a mental health service provider is to ask women if they have been abused; to respond to any cues given by women and create opportunities for disclosure; to educate women about the effects of abuse on their mental health and substance use, and identify abuse if necessary; to act as a professional support for women as they struggle to work through difficult circumstances related to the abuse; to act as a link or bridge to other community services and supports such as shelters or other counselling agencies and to prioritize safety planning with women.

This is often the most complex and lengthiest stage of the work. Some workers will develop a long-term relationship with the woman who makes the disclosure while others may have only a very brief intervention with her. Regardless of whether or not a service provider will be working with a woman over the long term, the principles of an appropriate response are the same. The goal is to help women experiencing abuse-related trauma to recognize that their mental health and substance use issues do not stem from their own personal deficiencies, rather from the adaptations they were required to make to survive the abuse they have experienced.

First-stage trauma response includes establishing safety, psycho-education, managing trauma responses and connecting women to appropriate supports and services. This means that women are not asked to uncover memories or early experiences of abuse. It is important to acknowledge any experience of abuse and support a woman to begin the process of understanding how the past affects the present. (Lori Haskell, 2004)

Recognizing and Identifying Post-Traumatic Stress Reactions

It is critically important that Mental Health and Addictions professionals learn to recognize and identify post-traumatic stress reactions because these reactions often manifest as symptoms of mental health problems or addictions. Understanding that they are normal reactions to trauma enables service providers to understand that the problems are not related to a pathology, but rather to external circumstances women have had to

address. This is taught in the training workshops and information is included in the Guide to Screening for Abuse. Lori Haskell's *Bridging Responses* Booklet (CAMH 2001) details the following post-traumatic stress responses:

Mental Health Problems

- depression
- chronic difficulties sleeping
- dissociation (losing conscious awareness of the here and now; a feeling of spacing out)
- depersonalization (feeling like an outside observer of one's own body or mental processes)
- derealization (the external world seems unfamiliar or unreal)
- anxiety disorders, such as panic attacks

Impaired sense of self

- shame, guilt and self-blame
- self-hate and self-loathing
- damaged, defiled or stigmatized
- helpless or paralyzed in terms of taking initiative
- completely different from others (may include a sense of being special, being utterly alone, or a belief that no other person can understand them)

Relationship difficulties

- unable to trust others
- frequent conflicts
- not feeling entitled to set boundaries
- repeated search for rescuer (may alternate with isolation and withdrawal)
- sexual difficulties
- unable to develop and maintain close attachments
- experiences of revictimization (adult sexual assault, involvement with physically or emotionally abusive partners)
- issues with sexual identity

Problems with memory

- gaps in memories of childhood
- difficulty remembering discussions from the previous week
- amnesia or intense recollection of traumatic events

Behavioural expressions of distress

- problems with alcohol or drug use
- suicidal impulses
- self-inflicted harm
- eating disorders
- shoplifting
- high-risk sexual behaviours that may result in unintended pregnancy or STDs

Physical problems

- chronic pain with no medical basis (often gynecological problems with women)
- stress-related conditions, such as chronic fatigue syndrome or fibromyalgia
- headaches
- sleep disorders
- breathing problems or asthma

Safety

Establishing safety is the first concrete step in the healing and recovery process. Emphasizing safety helps women understand that the many difficult life changes they must make have a purpose, that being to restore a sense of personal power and control. All mental health and addictions professionals can help women with this task.

A safety plan represents possible strategies that can increase a woman's safety and prepare her in advance for the possibility of further abuse. A safety plan is needed whenever the potential for abuse is identified. The plan will identify options and reduce risk. It is an ongoing process. There is an important difference between safety planning and crisis planning.

During the training sessions, the need for staff to look at safety planning from a broader perspective was identified. Women who are hungry and sleep deprived are more likely to use substances and/or be victimized. Helping women to connect with resources that provide basic necessities, such as a soup kitchens and safe drop in centres is part of the safety planning process. Helping women to plan how and where to spend their time is essential to keeping them safe. This includes helping women to identify safe and unsafe people in their environment.

Establishing safety involves developing an immediate safety plan for a woman and her children, a risk assessment, assistance with consultations and connections to appropriate woman abuse/sexual assault services, finding safe housing, accessing her support system, assessing suicide, self-harm and homicide risks, making referrals to assess physical, mental/emotional or spiritual needs and if needed developing a treatment plan to address substance use.

Education

Education helps a woman to learn how trauma affects how she thinks, feels and acts. She may learn about flashbacks, dissociation or numbing.

Managing Woman Abuse-Related Trauma Responses

Mental health and addictions professionals can help women manage their trauma responses by teaching them how to ground themselves, or feel connected to the present. Professionals can use many strategies, and training in this area is very important for front line workers doing the screening.

Key Goals

The goals for helping women in first-phase trauma response include:

- increasing the woman's sense of control over their lives, by familiarizing them with post-traumatic responses and the reasons for those adaptations;
- helping women learn coping skills. Some women will tend to neglect medical problems and need to learn the basics of self-care; e.g., proper eating and sleeping habits;
- helping women recognize that their lives are profoundly shaped by the contexts within which they live. This includes an understanding that prejudice based on gender, race, class, ethnicity, sexual identity, age and disabilities can contribute to, or is the basis of, the challenges women experience;
- Increasing women's sense of safety in their work, home and living environments by helping them to identify areas of potential danger or victimization and take active steps to protect themselves;
- helping women identify their own responses to trauma and reframe them in a non-blaming way;
- helping women see how their current life struggles have been affected by the trauma and its after-effects;
- supporting women as they attempt to foster relationships with supportive people.

(Lori Haskell, 2003-First Stage Trauma Treatment: A Guide for Mental Health Professionals Working with Women, pp. 65-66)

Project Overview

This was a two-year pilot project to adapt and implement the Routine, Universal, Comprehensive Screening tool (RUCS) at multiple sites representing both mental health and addiction services in London & Middlesex County. The RUCS tool entails a process to identify women and girls 12 years of age or over who have experienced physical, sexual or emotional abuse occurring in childhood, adolescence or adulthood.

A full time Project Coordinator was responsible for organizing and coordinating the participation of the eight mental health and addiction partner agencies involved. The Project Advisory Committee, composed of representatives from the mental health, addictions and violence against women sectors, met regularly to reflect upon and guide the work of the project.

The Advisory Committee member representing the Canadian Association for Mental Health assisted with the evaluation component of the implementation. Evaluation data was collected from a baseline survey, from workshop evaluations and focus groups after implementation had begun.

This project had four key stages. Stage I involved the assessment of current practice. This provided a baseline from which the impact of the proposed training and implementation of the screening protocol could be measured. Stage II involved the design and delivery of training to staff in the field. Stage III monitored the implementation at the sites and collected data collection. The final stage focused on sustainability and evaluation. Each stage is explained in greater detail below.

Based on client service levels at the eight participating sites, it is estimated that more than 2000 women are and will continue to be impacted through the use of the screening protocol annually.

Stages of Work

Stage I: Baseline Evaluation. In order to measure the impact of the proposed training and implementation of the RUCS protocol, baseline measures were identified to provide a profile of current practice. This included when, how, and if women are identified, the kinds of supports provided by the agency, how those supports are delivered and the types of referrals made. Information about current practice was gathered both from the service providers and from the women receiving service from the site.

Stage I also involved site visits to identify key contacts, to establish working relationships with participating sites, and to establish where within the service, the protocol ought to be implemented (i.e., would it be better at intake, or within case management service delivery).

Stage II: Design and Delivery of Training. Staff training in the area of woman abuse was key to the successful implementation of the screening protocol. Training was delivered through collaboration with Violence Against Women agencies. Every staff member from

every site had the opportunity to attend one of eight one-day workshops in this area. Utilizing principles of adult learning, the workshops incorporated the personal stories from women affected by abuse in their lives. The training also incorporated an introduction to the screening protocol.

Stage III: Monitoring and Implementation. As a follow-up to the one-day workshop, on-site training was provided at each of the sites to ensure the implementation of the protocol met the needs of each participating agency, that data was appropriately collected, and the staff felt comfortable with the protocol. On-going support was available throughout the duration of the project.

Stage IV: Sustainability and Evaluation. It is recognized that disclosure of abuse has an impact on staff. Providing staff with information and support on self-care as it relates to vicarious trauma was key to the success of the implementation of the screening protocol. This is important if staff is expected to continue using the protocol after the project. To further sustain the project, train-the-trainers workshops were offered to individuals within agencies to ensure they could continue to support and train current and future staff on the use of the protocol. Finally, during this stage, data was collected, analyzed and a final report prepared for the Ontario Trillium Foundation.

Tools that are needed to implement woman abuse and abuse-related trauma screening in mental health and addiction agencies are contained in the appended *Guide to Screening for Abuse* and in other appendices of this manual. Important activities in the process included:

- the baseline survey;
- Workshop Series for Community Mental Health and Addiction Service Providers
 - Woman Abuse Awareness (Sept./Oct./03) –Asking the Question about Abuse
 - Creating Safety for Women (Apr./04) –Responding to Abuse Disclosure
 - Additional Option: Women and Trauma Workshop (Lori Haskell, CAMH-May/04);
- evaluation of workshops;
- focus groups after implementation phase.

Baseline Survey

The Project Coordinator explained the importance of collecting data about current practices through a baseline survey to staff of partner agencies in this way;

In order to measure the impact of the workshops and my involvement at your agencies we need to find out what is happening currently related to abuse screening. This is not a comparison of how your agency rates when it comes to woman abuse screening, nor is it a comparison among workers. This evaluation is not of you as a helping professional but of the project and if we are doing our job, which is to meet the objectives listed below:

- improved identification of women who have had experiences and/or are experiencing abuse in their lives;
- increased recognition of abuse/trauma and the impact it has on health;
- improved linkages/relations and awareness of violence against woman services;
- increased skill competency to effectively respond to and support women in service.

The questions asked on the Baseline Survey (see Appendix II for a copy) addressed a variety of topics including;

- whether staff currently ask women if they ever experienced abuse;
- if they were asking a routine or indicator-based question;
- the age of women when they begin to ask;
- the types of abuse they ask about;
- whether the abuse is documented and how;
- whether the agency has a protocol for dealing with disclosure;
- an estimate of how many women have disclosed abuse;
- what is done when a woman discloses abuse;
- whether safety planning is discussed;
- whether staff are familiar with local resources;
- their knowledge of woman abuse and their comfort level discussing it;
- barriers for implementing screening;
- suggestions for screening.

Tabulated quantitative results of the Baseline Survey are presented in appendix III. The most surprising result of the Baseline Survey was the fact that eighty per cent of staff reported screening women for abuse while the same percentage of women who access service reported not having been asked the question about abuse.

Upon closer examination of the current practice of partner agencies in 2002, it was determined that staff were screening for abuse, but not in a systematic or consistent way. They were often unsure of the type of abuse and whether or not it was current or past. If screening did occur, it happened at case management, not in other programs (housing, social recreation, groups, information/referral).

Staff from mental health and addiction services did not use the woman abuse language of “safety plan,” “woman abuse,” “dissociated,” “survival skills.” They used terms such as “crisis intervention,” “PTSD,” “symptoms,” “relationship problems,” “codependency,” “borderline” and/or “manipulative.”

The results of the Baseline Survey offered an opportunity for representatives from the mental health and addictions sectors and representatives from the violence against women sector to begin a dialogue. All were talking about the same women and the same issues regarding woman abuse and abuse-related trauma, but within different frames of reference. The language of “first stage trauma response” provided language and a frame of reference to which both sectors could relate.

As these discussions evolved it became clear that a crisis plan, commonly used by the mental health sector is different than a safety plan, commonly used in the woman abuse sector.

It also became clear that mental health professionals considered the use of grounding techniques and DBT (mindfulness/being fully present) as part of “therapy.” Prior to the cross-sectoral workshops and discussions generated by the project, they were not routinely providing a first-stage trauma response.

This information informed the development of training for mental health and addictions workers.

Design and Delivery of Training

Developing Training Workshops

A variety of training presentations were developed and delivered for the project. Training participants included intake/assessment staff, community support staff, nurses, shelter workers and substance abuse counsellors. Both management and front line staff attended presentations about:

- woman abuse awareness;
- sexual abuse awareness;
- implementing a woman abuse screening protocol in community mental health and addictions settings;
- how to screen and respond to abuse disclosure;
- children exposed to woman abuse;
- duty to report: legislation and information;
- vicarious trauma.

In the development of the training, it was important to consider the various educational backgrounds of potential participants and their spectrum of training experiences.

Copies of the powerpoint outlines for many of the presentations will be available on the WMHAARC website http://www.wmhaarc.ca/Building_Connections.htm.

Collaborative Community Relationships

In keeping with the collaborative and community building nature of the project staff from a number of local agencies assisted with the development and delivery of training. These agencies included urban, rural and First Nations shelters, the sexual assault centre, a woman abuse counselling service, a male batterers' counselling services, and the Children's Aid Society.

A networking group developed as a direct result of this project. The group met to develop further training specific to woman abuse issues for rural and farm women within Middlesex County. A workshop was developed specifically for the partners serving the rural areas of Middlesex County.

Experts on these issues are available in communities across the province. The resources developed during this project can serve as a guide for organizing a training process, but ultimately the success of an initiative to implement woman abuse screening in mental health and addiction agencies will depend upon building relationships and designing collaborative processes with local woman abuse and sexual assault experts.

Minimum Requirements for Training

The organization preparing to implement screening also had to meet certain preconditions. These included:

- buy-in from all levels of staff; both front-line and management;
- site representatives to lead the process and a coordinating structure;

- an understanding that screening is a process that requires ongoing commitment and follow-up;
- an agreement to be involved in Participatory Action Research;
- a screening protocol to use as a guideline;
- a willingness to address staff needs, including vicarious trauma and the development of comfort levels to discuss abuse.

Woman Abuse Awareness and Screening Workshops

Key terms and concepts that were discussed included woman abuse, violence against women; feminism; equality; woman abuse; types of abuse including sexual, physical, emotional and spiritual; forms of oppression including, internalized oppression, white privilege, male privilege and heterosexism.

At the beginning of the workshop trainers recognized that some of the participants may be workers who had been abused, either as children or as adults. It was acknowledged that it is difficult to be present as a professional with these personal experiences and explained that while they may not feel safe to disclose to the group, the fact that they have been abused provides them with important insights into the work. Trainers also explained that their history can make them vulnerable to being triggered by the workshop or by their clients. It was clear that it is okay to participate in dual roles, as a survivor and as a professional. The trainers advised of the need for everyone, including the participants that hadn't been abused to take care of themselves as needed, because of the risk of vicarious trauma.

Ground rules were covered and participants were assured that confidentiality would be observed. Participants were asked to be honest and supervisors were asked to act respectfully and not use any information disclosed in the workshop against workers.

The question of why the screening was only being suggested for women was discussed as well as the importance of asking women about abuse and giving them an opportunity to voice their story.

The results of the Baseline Survey, conducted at participating agencies, were shared with project participants at the initial workshops on woman abuse screening and woman abuse awareness. This was part of the participatory action research process and provided a starting place for the important discussions that were to follow about the specifics of screening for woman abuse.

Workshop Topics

Topics covered in the training workshops included:

- Talking About Abuse
 - comfort level
 - client-centred goals
 - understanding of violence and abuse against women and children- the global picture
 - knowing your role as a service provider
 - clear boundaries and safe container
 - grounding techniques
- Initiating the Conversation- Suggestions
 - safe environment
 - explanation of the reasons to screen for abuse
 - safety concerns
 - interview the woman alone
 - confidentiality
 - duty to report
- Walking With Her- Witnessing Disclosure
 - need for supervision
 - boundaries
 - vicarious trauma
 - recognizing women's strengths and survival strategies
 - safety, safety, safety
 - creating safety after disclosure
 - dissociation
 - women's memories and denying disclosure
 - high risk situations
- Resources
 - appropriate information and referrals
 - standardized safety plan
 - high risk indicators
 - professional development
 - documentation practice
 - Lori Haskell, First-Stage Trauma Treatment: A Guide for Mental Health Professionals Working with Women, CAMH, 2003
- Important Things to Remember
 - know the type of abuse, however it may be more damaging to illicit details
 - the woman is doing the best she can given her circumstances
 - prioritize safety and stabilization
 - consult with other professionals
- Potential Barriers to Screening
 - education and training
 - comfort level with the issue
 - fear of offending the client
 - time with the client
 - being a survivor

Learning Objectives

Key learning objectives for the initial training were:

- understanding the importance of screening for abuse issues, more specifically for abuse that is experienced in our society by women and girls;
- identify unique concerns of women who identify as being abused with substance abuse and/or mental health issues;
- developing enhanced sensitivity towards women who have experienced trauma or women who are currently in relationships with abusers as well as identifying mental health and/or addiction issues;
- discussing case scenarios that involve woman abuse;
- applying the screening protocol through role playing;
- identifying ways in which staff are impacted by disclosures related to women abuse;
- networking, dialoguing and sharing ideas with other social service providers working in the woman abuse, mental health and addiction sectors.

To review the agenda for the initial training see Appendix IV

A follow-up training workshop was subsequently developed. It focused on creating safety for abused women in mental health and addiction agencies through appropriate response to abuse disclosures. Internal woman abuse trainers from collaborating agencies facilitated small group discussions of case scenarios.

To review the agenda for this training see Appendix V

The Role of Addiction and Mental Health Counsellors

It was important to build trust with service providers during the training process because the training was suggesting the need for some fundamental changes in the way the work is done. Relational skills helped with this process. The role of an addictions counsellor or a mental health practitioner in implementing the screening protocol was negotiated. Agreement was reached to:

- ask women if they have been abused;
- recognize the signs of abuse-related trauma and build rapport with a client so that she feels comfortable disclosing her experiences of abuse;
- prioritize safety planning and stabilization with clients;
- educate women about the effects of abuse on their mental health and /or substance use/problem gambling;
- model healthy ways in which to use power;
- act as a professional support for women as they struggle to work through difficult circumstances related to the abuse;
- act as a link or bridge to other community services and supports such as shelters or other counselling agencies.

Many staff related well to a trainer who was a mental health professional with a trauma background. Concurrent models discussing addictions, woman abuse and abuse-related trauma, and mental health were presented.

Tools

Staff requested hands-on tools. They wanted to know how to adequately respond to women when they disclose? A standardized safety planning tool was introduced during the workshops to encourage a consistent approach to creating safety for abused women by service providers within community mental health and addiction settings. Networking among the sectors (referral agencies) occurred.

The most relevant information staff need to know about woman abuse and abuse related trauma, asking about abuse and responding to disclosure is summarized and compiled in *Asking Women about Abuse and Responding to Disclosures of Abuse: A Guide for Addictions and Mental Health Professionals*. A copy of the Guide is included in the back cover of this manual.

Sustainability through Woman Abuse Trainers

To support the sustainability of the project, a train-the-trainer workshop was offered to individuals within the partner agencies to ensure they would be able to continue to support and train current and future staff on the use of the screening protocol. Sixteen woman abuse trainers were identified from the twenty-four programs involved in the implementation phase of the project. They met on average once a month for two hours to discuss issues related to the Screening Protocol and to identify emerging staff needs.

The Woman Abuse Awareness Workshop evaluation results were shared with the woman abuse trainers from each partner agency, as well as with the project supervisory committee to determine further training needs of project participants. The woman abuse trainers continue to play an extremely important role in sustaining the implementation of the screening protocol for abused women in their agencies. Because this was a new role, some trainers needed to review their role with agency management. The Project Coordinator was available to answer questions or address concerns if they arose.

The woman abuse trainers discussed the following topics in their regular meetings with one another:

- grounding techniques;
- safety planning;
- asking questions about abuse through role play;
- being inclusive of all programs involved in project (crisis, counselling, community support, residential);
- best practices for documentation;
- interagency communication;
- indicators of abuse;
- what to do about “opening a can of worms”;
- supervision structure: how to address vicarious trauma issues.

Debriefing

As the screening protocol was implemented and agencies saw an increase in woman abuse disclosures, it became increasingly important for staff to debrief with co-workers or during supervision either individually or in a group. The project coordinator encouraged woman abuse trainers to review issues related to this through facilitated discussions with consideration being given to:

- How the supervision/debriefing process works within each organization?
- Suggestions to improve the supervision process (with both peers and supervisor) at each place.
- An assessment self-care within each workplace. Staff were asked to rate the following areas in frequency:

5 = frequently/4 = occasionally/3 = rarely/2 = never/1 = it never occurred to me

- ___ taking a break during the workday, (i.e. lunch)
- ___ taking time to chat with co-workers
- ___ making quiet time to complete tasks
- ___ identifying projects or tasks that are exciting and rewarding
- ___ set limits with clients and colleagues
- ___ balancing caseloads to avoid a part or whole day as being “too much”
- ___ arrange work spaces so they are both comfortable and comforting
- ___ getting regular supervision or consultation
- ___ negotiating to have individual needs met, i.e., benefits, flex-time
- ___ having a peer support group
- ___ developing a non-trauma area of professional interest
- ___ other:

- How identified areas of self-care can be improved in the workplace, to assist in better addressing individual needs.
- The goal in discussing the importance of debriefing within each organization is to find problem-solving solutions. Mental health and addiction staff experience burnout and stress. Remember to keep the group focused on positive outcomes instead of becoming more burdened with the many challenges that are witnessed day to day as overwhelming issues are addressed.

Community Awareness

In addition to the training workshops presentations were given within the local community to other helping professionals regarding the project’s development and the importance of screening for woman abuse. These presentations were delivered to the Social Work Department at London Health Sciences Centre, St. Joseph’s Health Care, Regional Mental Health Care Centre for London and St. Thomas, students in the Social Service Worker Program at Fanshawe College, and the Task Force on Health Effects of Woman Abuse at the Middlesex London Health Unit. Presentations were also made at conferences for mental health, addictions and woman abuse professionals.

Implementation

The Purpose of Screening

Understanding the purpose of screening is a necessary first step in implementing a screening process. The reasons to screen for woman abuse are:

- To identify any abuse experienced by the woman, either in the past or in the present, so that this history can inform any health care and/or therapeutic interventions she may seek.
- To decrease the incidence and prevalence of woman abuse by ensuring that mental health/addiction staff and other community support services identify and respond appropriately to cases of woman abuse with effective treatment, documentation, safety measures and referrals.
- To strengthen the woman/counsellor relationship.
- To assist the woman in acknowledging what has happened to her and to help her deal with, for instance, her feelings of guilt and shame.
- To educate the woman about the connection between woman abuse and abuse-related trauma responses.

Getting Ready to Implement Woman Abuse Screening

The value base and philosophy of an organization will set up the conditions for screening for woman abuse and will determine whether screening can be successfully implemented. All levels of the agency - board, management and front-line staff need to recognize the impact of woman abuse and the importance of screening. Staff must be supported in their efforts to implement screening and appropriate resources need to be allocated for ongoing training and implementation costs.

In some respects, the workplaces are microcosms of the larger society and there has to be an expectation that some staff will be survivors of woman abuse. In preparation for this, the possibility of providing appropriate supports through supervision and insistence on self care should be discussed openly. The section on vicarious trauma (page 42) has suggestions that will also be helpful for addressing the needs of staff who are survivors.

It is perhaps even more difficult to come to terms with the fact that occasionally staff can also be abusers. This problem was encountered during the implementation stage of the project. If the workplace is not safe for staff, implementing the screening will be problematic until staff issues such as harassment in the workplace are addressed.

Abusers and Survivors Work in Mental Health and Addiction Agencies

It is important to recognize and to prepare for the fact that both abusers and survivors do work in agencies. Implementing woman abuse screening will result in an increased awareness of the dynamics of abuse and the need for safety in the workplace as well as in the lives of the women we serve.

During the project, staff at one of the participating agencies did identify an abusive co-worker. The Project Coordinator was able to provide support to the female staff member who was being harassed and bullied by a male coworker. The problem was brought to the

attention of management. The management of the agency acted to remove the abusive person from the workplace. This situation is discussed in more detail on page 93. It is critically important for all workplaces to have policies and procedures in place to address workplace harassment and bullying and for all staff to be familiar with them.

Staff who are survivors of woman abuse and woman abuse-related trauma themselves can bring insights and compassion to their work with other survivors. They can also be triggered by their clients' experiences of abuse if they do not receive adequate supervision and support. This issue is also discussed in the qualitative evaluation on page 92. Again it is important that every workplace ensure its staff are receiving the support and supervision they need and that self-care is a job expectation.

Barriers to Implementing Woman Abuse Screening

Service providers remain silent on the subject of women abuse for a number of reasons, some of which are listed below. It is important to be aware of these barriers and to address them in training and in the ongoing process of monitoring the implementation of woman abuse screening. Barriers include:

- Lack of information and training about abuse and, therefore, discomfort with asking if the woman is a survivor of abuse and uncertainty about what to do if the woman responds positively that she has been abused when asked.
- A belief that abuse is a “private” or family matter rather than a societal problem and health concern.
- The effects of the provider’s own traumatic experience(s) witnessing or experiencing abuse, either past and/or present.
- Concerns about the legal ramifications of knowing this information.
- Discomfort with women expressing emotion and concern about setting time boundaries.
- Concern about how listening to these experiences will affect the service provider.
- A feeling of helplessness to intervene.

There may be hesitation to screen some women. It is important to understand why it seems harder to approach these women. An eighty year old woman may be perceived as too old to ask. However, she may have been sexually assaulted many years ago and may never have been given permission to talk about the assault. She may also currently be experiencing abuse from a spouse, an intimate partner, caregivers or younger relatives. Similarly a pregnant woman may not seem to be the appropriate client to ask about woman abuse, yet it is known that pregnant women are at risk for being abused and/or killed by their partners. Teenage girls who have been exposed to sexual or physical violence are at risk for substance use and early pregnancies.

Guidelines for Implementing a Woman Abuse Screening Protocol

Step-by-step guidelines for implementing a Woman Abuse Screening Protocol are provided in this section. As with all resources provided in this manual, the guidelines are intended to be a template and should be customized to meet the needs of each individual agency.

Preparing Staff

The following steps will be useful for an agency preparing to implement woman abuse screening:

- Designate an appropriate number of Woman Abuse Awareness Trainers to attend train-the-trainer sessions to acquire specialized knowledge about woman abuse and to liaise as necessary with service providers from the violence against women sector.
- Ensure that all staff schedule time to review and read all material contained within the *Asking Women about Abuse and Responding to Disclosures of Abuse: A Guide for Addictions and Mental Health Professionals*. A copy of the Guide is included in the back cover of this manual.
- Ensure all staff attend training on woman abuse as part of their professional development activities.
- Ensure that new staff review *Asking Women about Abuse and Responding to Disclosures of Abuse: A Guide for Addictions and Mental Health Professionals* with one of the identified Woman Abuse Trainers on their staff team.
- Provide all staff with immediate access to:
 - The Abuse Screening Documentation Form, to be used as a clinical tool to assess women's safety and related mental health issues. A template of this form is provided in the *Guide* referred to above, but all staff need to familiarize themselves with the Woman Abuse Screening Protocol specific to the workplace.
 - The Safety Plan, to be utilized with women who report being abused. The safety plan is also to be used to assess staff safety both in the workplace and when out in the community visiting clients. (see the *Guide to Screening for Abuse*)
 - Updated information on woman abuse and abuse-related trauma services in the community that can be resources for women.
 - Information and training on under what circumstances it is the responsibility of every staff member to report when a woman discloses her children are being or have been exposed to woman abuse.
 - The Power and Control Wheel (see Appendix I)
- Lori Haskell's book: *First Stage Trauma Treatment for Mental Health Professionals* (2003) is a useful resource for staff to review.

Asking the Question

Remember the role of the service provider specific to the Woman Abuse Screening Protocol is:

- to ask women if they are being or have been abused;
- to respond to any cues given by women and create opportunities for disclosure;
- to educate women about the effects of abuse, and identify abuse if necessary;
- to act as a professional support for women as they struggle to work through difficult circumstances related to the abuse;
- to act as a link or bridge to other community services and supports such as shelters or other counselling agencies;
- to prioritize safety planning with women.

It is always important to begin by explaining why the questions related to abuse are being asked and to document the answers. The way in which a professional asks the question will depend upon the situation, the relationship with the woman, the clinical issues, and personal style.

Please keep in mind that when screening women for abuse, it is essential that no one else be present with the woman, even another helping professional. Women need to be asked about abuse in a safe, secure and confidential environment. If a woman requests that a support person be present, air on the side of caution when asking questions that could jeopardize the woman's safety. At no time should the woman's partner be present, even as a support person or an interpreter. As a professional it is important to ensure that no one can overhear the woman's response to the questions related to abuse. This is essential in ensuring the safety of the woman. For this reason, it is recommended that screening not take place over the phone or in a public place.

Always ask for the woman's permission to ask her questions relating to abuse. Preface the questions with an explanation of why it is important to ask about woman abuse. Women need to know that they are not alone and all women are asked these questions as a matter of routine. Further women need to be advised that their answers will be respected and confidential. It may be necessary to reassure women that there is no requirement to report abuse if the woman being abused is an adult. The local Children's Aid Society, or the agency's solicitor can provide information and possibly training on the duty to report abuse involving children under the age of 16.

Some Examples of How to Ask the Question

Calm matter-of-fact direct questions elicit the best response. The following examples anticipate a number of different possible settings and contexts for the helping professional:

"I'm going to ask you a few questions now about any experiences you might have had with physical, sexual or emotional abuse. I have found that many of my women clients have been hurt through one or more types of abuse, and I'm wondering have you ever experienced abuse as a child or as an adult?"

"At our organization, we always ask women about any history they may have had with abuse. Because women so often experience physical, sexual or emotional abuse as children or as adults, we have begun to realize how seriously abuse affects women's health. Every woman who comes through our intake or assessment process is asked these questions. Have you ever experienced any form of abuse, either within the past year or ever in your life?"

"Here, at the agency, we have been learning more about the links between women's trauma, mental health and addiction and as a staff we have decided it is important to ask each of our clients that access case management services whether she has experienced physical, sexual or emotional abuse, either as a child or an adult. Have you ever been hurt by someone in any of these ways?"

“You have been a client of the agency for a long time. You and I have worked together for years, but I see from my notes that we have never discussed the issue of abuse. In mental health and addictions, we now know that abuse is a factor in a majority of women’s lives and that it causes serious health effects. It is now my practice to ask every woman about whether she has ever been hurt or affected by physical, sexual or emotional abuse, either as a child or adult. Has anyone ever abused you?”

“I am very concerned about the number of hospitalizations you have had in the past six months, and I have heard how disappointed you are that the treatments you have tried don’t seem to be giving you any relief. I realized the other day that we have never explored any experiences of abuse you may have endured in your life. I know that sometimes, chronic stress and lack of sleep is made much worse by the unresolved anguish of physical, sexual or emotional abuse. Has abuse been an issue for you?”

“I’m really concerned about how unhappy you seem to be. We’ve tried a number of ways in which to cope with your depression but, so far, nothing seems to be helping. Have you ever felt this way before or is it something that has begun only lately? Can you think of anything that may have hurt or upset you in your life that would be causing you to feel this way now?”

“I am concerned about the injuries you have sustained. It is very unusual for these kinds of (bumps, bruises, fractures, loosened teeth, cuts, etc.) to have resulted from the kind of (fall, trip, accident, etc) you describe. In fact, these injuries look to me as if someone else has caused them. This is a very safe place to tell me what has happened to you to cause such injuries.”

“When I was reviewing some of my notes I noticed that we have never completed the questions that I now ask of all the women I see for counselling/community support. I ask women about their experiences of abuse, either from when they were children, adolescents, or adults. Statistics tell us that a majority of women experience some form of physical, sexual or emotional abuse during their lives. Because there are serious health effects (mental health/addiction problems) that arise as a result of abuse, I need to know if you have experience any form of abuse that may be affecting your health.”

The language used is important and should be used carefully. The term “woman abuse” is one that may be unfamiliar to women. Instead ask the woman whether she has ever been afraid of her partner or relative. Ask her if someone has asked her to participate in a sexual activity against her will. Remember it is important to know whether the woman has experienced any form of abuse in her life, including past or present physical, sexual, emotional, institutional, war-trauma or other types of abuse.

When Women Claim “No Abuse”

If the woman does not disclose a history of abuse and there are no recognizable indicators of abuse present, acknowledge and accept her response. As a mental health worker, take the opportunity to have a conversation about the various forms of abuse and the common health effects of abuse. Many women do not recognize that what they experience is abuse; the behaviour has become normalized for them.

When the answer is “no,” but the indicators of abuse make you suspect abuse then discuss this openly with the woman. Share information about how these symptoms are often associated with physical, sexual or emotional abuse. Offer educational information about the health effects of abuse.

Make sure to point out the referral services available in the community. Provide her with information about 24 hour crisis lines. Let her know that she can approach her counsellor/therapist for information and support, should she need assistance.

When Women Disclose Abuse

When a woman discloses, ask whether the abuser continues to have contact with her or her children and if so, the frequency and nature of the contact. Ask whether she is feeling safe now. Inform her that she will be assisted her with a preliminary safety plan before she leaves.

It is important to keep in mind when hearing the disclosures of abuse that if the abuser is an intimate partner who lives in the house, the safety of all people in the house needs to be assessed (this includes an assessment of whether any children have been exposed to woman abuse).

Many women feel bound by religious and cultural imperatives to remain in a marriage no matter what pain that entails. Those beliefs need to be respected and considered, no matter how strenuously a helping professional disagrees with them.

Women may also believe that they are at even greater risk of abuse or lethality if they leave the abuser. Separation does increase the potential risk of escalated tactics of abuse and homicide. The worker must respect a woman’s expertise on her own life and not judge a woman’s decision to remain with the abuser.

The helping professional must also be careful not to alienate the woman by criticizing her partner too vigorously. Always focus on the abuse itself and how to end it, rather than on the character of the abuser or the future of the relationship.

Safety Check/Safety Planning

Section D of the Guide to Screening for Abuse, which is included in the back cover of this manual, provides information on safety planning. A plan should be completed or reviewed anytime a client discloses abuse and at each appointment. The safety planning information should be read in advance of discussing it with the woman to ensure

familiarity. Have copies of the plan available at all times when providing support to women.

Immediate Risk

A number of questions may help determine immediate risk.

- If the abuser has accompanied the woman to her appointment and is in the agency, ask:
 - Does the client believe the abuser may pose a danger to her, her children or health care providers?
 - Is it necessary to seek help from the police or security?
 - Is the abuser suspicious about this interview?
 - Has the abuser tried to insist that the interview include him?
 - Remember that the immediate danger to the woman increases if she has decided not to remain with the abuser or to call the police.
- It is important to note that an intimate partner often senses a change in a woman who has disclosed abuse and begun to deal with her feelings about it. If the abuser is her intimate partner ask:
 - Does the woman plan to return home and what is her own assessment of the risk?
- If the woman has recently separated from an abusive intimate partner, ask:
 - Has the partner ever threatened to kill her or given her any reason to believe that the partner might kill her if she left?
 - Has the abuser stalked or harassed her since the separation?
 - Does the abuser have access to a gun?
 - Has the abuser ever threatened the woman with a gun or other weapon such as a knife?
 - Has the abuser ever threatened the woman with another type of weapon?
 - Has the abuser threatened or attempted suicide?
- If the abuser has a history of substance abuse, ask:
 - Is the abuser more violent or abusive when under the influence of drugs or alcohol?

Documentation

Once there is a disclosure of abuse, the woman's record should include:

- Details of the disclosure(s) of abuse and the woman's statements regarding the impact of the abuse on her mental health.
- Referrals to appropriate community services.
- A copy of the woman's safety plan or details of the discussion between staff and the woman regarding her safety plan.
- A notation that the woman has been offered educational material(s) about the nature, prevalence, dynamics and health effects of woman abuse.

If when screening for abuse, the woman answers the questions by stating she has not been abused, then the woman's record need only show that the screening has been applied and the result is negative or unknown. Alternatively, if the woman answers the above questions by stating that she has been abused, the woman's record should include

information about the screening and show the response to be positive. If the woman is unclear in her answers, her record would indicate the screening has taken place and her response was “unknown,” (use clinical judgment- i.e., if the woman is apprehensive of disclosing that her children have been exposed to woman abuse for fear of involvement with child welfare. The category “unknown” would be appropriate to use in this circumstance).

Bearing witness to abuse disclosure is one of the most emotionally challenging aspects of working with women in the mental health field (see information on vicarious trauma for more information).

Referral and Follow-up

It is critical to continue to develop strong ties to the agencies that provide woman abuse and abuse-related trauma counselling and other supports to the women being seen. The list of referral agencies should be continually updated and shared with all agency staff. Participation in opportunities to join in committee work or community development projects that aim to eliminate the barriers experienced by women within the mental health and addiction sectors are encouraged.

Bearing Witness to Woman Abuse Disclosures

By asking women about violence, the door for them to disclose has been opened. Some women may be able to walk through that door right after it has been opened, but it will take more time for others. Ensure that the door is always open. When women are ready, they will walk through it.

Mental health professionals describe a moving forward, slipping backward progression that women who disclose abuse experience as they come to terms with their situation. This can be frustrating for the worker whose instinct it is to “save their client”. Mental health practitioners who practice from a client centred model, recognize the need to “walk with” clients as they struggle with the decision-making process related to the abuse they have experienced. These workers choose to see their clients’ steps toward personal growth as individual successes.

Vicarious Trauma

Workers describe how witnessing the trauma of others can be distressing, evoking a range of intense feelings; from fear about the safety of the woman or for themselves; to anger, frustration, worry, helplessness and doubt in the worker’s professional ability. Disclosure of abuse from women can also trigger helping professionals who have experienced abuse and violence in their own lives. Many workers also report how rewarding their work is when they are able to assist women after disclosure. Workers describe feeling honoured that women trust and share their stories of survival with them.

In addition, many staff describe self-care strategies used to deal with the impact of bearing witness to disclosure of abuse that include, but are not limited to debriefing with others and physical activity.

Whether staff are new or are individuals who have been doing the same job for the past twenty years, it is important to provide adequate supervision and an opportunity for peer mentoring at each organization.

Professional development opportunities can increase the comfort levels of professionals who work with women who have survived woman abuse and abuse-related trauma. These opportunities allow mental health workers to learn from professionals in the woman abuse sector better ways of asking questions regarding abuse as well as appropriate responses to disclosures. They also provide an excellent opportunity to learn more about community resources.

Health Canada has produced an excellent resource for agencies wanting to address the issue of vicarious trauma experienced by staff. The *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* is available on the National Clearinghouse on Family Violence website at http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/trauma_e.pdf.

(Adapted from The Task Force on the Health Effects of Woman Abuse: Final Report, Middlesex-London Health Unit, Sept. 2000; Nursing the Social Wound: Public Health Nurses' Experiences of Screening for Woman Abuse, Webster, Sangster Bouck, Wright & Dietrich, 2003; Improving Screening of Women for Violence - Basic Guidelines for Physicians, Stevens, 2003)

Guiding Principles of Applying the Screening Protocol

The Task Force on the Health Effects of Woman Abuse identified the following principles of applying a woman abuse screening protocol in their Final Report of September 2000.

Attitude and Approachability

- treat the woman with respect, dignity and compassion;
- be sensitive to differences in age, culture, language ethnicity and sexual orientation;
- state clearly that abuse is not the fault of the victim but the responsibility of the abuser;
- reinforce that no one has the right to use physical, sexual or emotional abuse to control another person's actions;
- reinforce that physical and sexual abuse are against the law in Canada;
- convey a non-threatening, non-judgmental stance in words, facial expressions and body language;
- express concern for her safety;
- acknowledge the strength the woman has shown in surviving abuse and disclosing it;
- offer support;
- avoid excessive criticism of the abuser;

- understand the established relationship with the woman will not change because of her disclosure;
- reinforce that she is not alone; this has happened to many women.

Believing Women Who Disclose

- show by your words and your actions that you believe her disclosure;
- remember that the fear of not being believed silences many women. The abuser may have convinced her that no one will believe her if she discloses;
- help her to understand that most of us try to block out memories that are too painful to deal with. If she is disclosing retrospective abuse, she may not be sure herself of exactly what happened or where;
- reassure her to encourage her to have confidence in her own perceptions about the abuse.

Confidentiality

- interview in private, without the woman's partner or family members being present;
- use a professional interpreter if one is required, not a friend or family member;
- To protect the woman's confidentiality, prior to asking about abuse, tell her directly about the policies and procedures used in each practice or institution;
- if the woman's disclosure about abuse and violence will not be kept confidential, she needs to be told this before she answers any questions;
- confidentiality means that files are locked in a cabinet and kept in a place to which only staff members have access. This information will not be reported to the authorities unless the woman herself decides she wants to do so;
- staff must also not discuss the information with one another unless it is relevant to the woman's service provision agreement;
- assure the woman that the information will not be released unless she gives her written permission to do so;
- outline the exceptions to this pledge of confidentiality (a) where child abuse or neglect is in question; (b) where the health professional has reason to fear for the safety of third party; and (c) where a file is subpoenaed by a court order;
- each province has its own laws regarding whether abuse and violence needs to be reported to the authorities. It is important to know these laws (i.e. The Child and Family Services Act, 2000);
- advise the woman that you are documenting the information she provides so that it will help in the provision of appropriate services.

Documentation

- document consistently and legibly;
- if more than one person has abused the woman, distinguish between the abusers;
- indicate the severity and seriousness of the abusive incidents;
- avoid subjective statements and speculations that might undermine the woman's credibility.

Education

- seek out information and education about abuse and its health effects;
- help the woman to understand that she is not alone and that help is available;
- attempt to engage the woman in long-term continuity of care by offering appropriate referrals and follow-up;
- know about available community resources and help the woman choose the services she needs, as she is ready to seek assistance;
- display posters, brochures and other available information about woman abuse in each office or institution. This allows clients to know that the organization and its staff are aware of the possibility of abuse and violence in women's lives;
- display material about abuse and violence in private places, such as the bathrooms, where the woman can read it without being seen;
- provide the woman with information about the **Assaulted Women's Helpline: 1-866-863-0511 or 1-866-863-7868 TTY or #SAFE(#7233) on a mobile phone** and/or local women abuse and sexual assault service providers.

Respect and Recognition

- respect the integrity and autonomy of the woman's life choices;
- recognize that the woman must deal with the abuse at her own pace;
- recognize that an abused woman is an expert about her own abuse and abuser;
- affirm the woman's strengths and the survival skills she has demonstrated;
- do not try to tell the woman what to do but help her understand the options available to her; she must choose the options she decides will meet her own goals and priorities;
- offer referrals to other specialized services and follow-up with them;
- do not label the woman as being resistant or non-compliant if she decides not to accept any advice; make it clear her rights to choose are respected and she will continue to be supported;
- help the woman to recognize that she cannot control the actions of others; she can only make her own decisions.

Tools for Implementation

During the project, each partner agency received a number of tools to assist with the implementation of the woman abuse screening protocol. These included:

- two full-day training sessions with presentations from local experts in the violence against women sector;
- written guidelines for implementing the screening protocol;
- information on post traumatic stress responses;
- abuse Screening Documentation Form;
- standardized Safety Plan;
- information on roles and responsibilities within agencies that include first stage trauma response;
- background information on woman abuse;
- woman abuse referral information;

- case consultation and case conferences with the Project Coordinator for the two year duration of the project.

The basic background information and tools needed to implement a screening protocol have been compiled in the booklet, *Asking Women about Abuse and Responding to Disclosures of Abuse: A Guide for Addictions and Mental Health Professionals*. (A copy of the booklet has been included in the back cover of this manual).

The Project Coordinator worked with representatives of each agency to adapt and customize the Abuse Screening Documentation Form for their data collection system. Many agencies have electronic data collection systems and the form was translated into electronic formats.

Throughout the duration of the project, the Project Coordinator provided on-site support to partner agencies as needed. Given the wide range of training and educational backgrounds, the Coordinator found it difficult to anticipate the needs of addictions and mental health workers. The Project Coordinator usually attended team meetings on a weekly basis. Support workers presented the cases where women had been screened for woman abuse and together a team approach was used to assist the workers if they encountered any issues or problems when asking questions regarding woman abuse. The Coordinator then provided individual follow-up for workers if needed.

A Continuum of Service

Relationships with women in the mental health and addictions sectors are based on a continuum of involvement ranging from crisis intervention to short-term and long-term community support.

Crisis service staff do not engage women in a way that supports an ongoing relationship. Many times crisis service staff will only interact only once with a woman. Screening protocols may be adapted to reflect this reality and more in-depth screening may occur when a longer-term relationship can develop between the service provider and the woman.

The depth of that screening is based on the comfort level of the woman as well as the type of service they are engaged in. Screening that occurs at a first time contact with women would be different than abuse screening that occurs during ongoing support when there has been time to develop rapport between the professional and the woman.

The quality of the relationship with the service provider is of primary importance when screening occurs, whether the relationship develops over time or it is in the moment.

When screening it is always important to take into account the fact that even although the woman is involved with support programs and services, this may be the first time she has felt comfortable disclosing information about her experiences of abuse. A positive and respectful experience may encourage women to consider further professional help.

Results of Screening

In completing the abuse screening forms, staff from the partnering agencies were able to generate disclosure rates for the first time as well as identify what information they wanted to collect in their database related to woman abuse. Staff from mental health and addictions sectors requested a safety plan once they began receiving disclosures. A safety plan was developed in consultation with partners in the violence against women sector.

The statistics are a useful way of beginning to understand how many women accessing mental health and addictions services experience abuse and what kinds of abuse they experience. The following statistics represent a snap shot of a specific time period during which woman abuse screening was completed.

Addictions Agency

- 130 women were screened;
- 80 per cent of women screened reported abuse.

Addictions Agency-Problem Gambling Program

- 25 women were screened;
- 20 per cent of women screened reported abuse.

Addictions Program for Pregnant and Parenting Women

Jan. 1 – Dec.31 2004 (n= 21)

- 21 women were screened (half of the new admissions);
- 94 per cent (15/16) women who completed screenings disclosed abuse;
- 20 per cent (3/15) of women disclosing, disclosed past abuse;
- 80 per cent (12/15) of women disclosing, disclosed abuse occurring within the previous 12 months;
- 6 per cent (1/16) of women who completed the screening reported no abuse but the documentation indicates they were separated from their partners while accessing treatment and there were current relationship problems;
- 24 per cent (5/21) screening forms were incomplete.

Mental Health Crisis Service

Aug.11/04-Mar.9/05

- 89 women were screened at the main office (36 per cent of women served).

Physical abuse

- 52 per cent reported past physical abuse;
- 10 per cent reported current physical abuse;
- 11 per cent reported past and current physical abuse;
- Total: 73 per cent of women screened reported physical abuse.

Sexual abuse

- 73 per cent of women reported past sexual abuse;
- 2 per cent of women reported current sexual abuse;
- Total: 75 per cent of women screened disclosed sexual abuse.

Emotional Abuse

- 47 per cent of women reported past emotional abuse;
- 2 per cent of women reported current emotional abuse;
- Total: 49 per cent of women screened disclosed emotional abuse.

Other Observations

- 45 per cent of women who reported having experienced abuse continue to have contact with their abuser(s);
- 47 per cent of women who disclosed abuse discussed a safety plan during their face-to-face appointment with staff;
- 9 per cent of women who disclosed abuse reported that their children had been exposed to woman abuse;
- 46 per cent of women have had support or are seeking professional support related to their abuse issues;
- 15 women were screened for abuse at the hospital (9% of the women served);
- 53 per cent of women disclosed having experienced physical abuse;
- 80 per cent of women disclosed having experienced sexual abuse;
- 53 per cent of women disclosed having experienced emotional abuse;
- Many women disclosed more than one form of abuse.

Mental Health Community Support Programs

Program A

- 100 per cent of women who were screened disclosed abuse.

Program B

- 60-80 per cent of women who were screened disclosed abuse.

Program C

- 60-80 per cent of women who receive community support have disclosed abuse.

Other Observations

- childhood sexual abuse and current intimate partner abuse most reported;
- 50 per cent of women who disclose continue to have contact with their abuser(s).

Residential Programs

- 100 per cent of women disclosed abuse for the stats gathered during a period of the project;
- 2/3 of these women were participating in mental health programs.

Other Observations

- the safety of women, other tenants and staff in housing programs is increased through safety planning;
- the extremely high rate of abuse indicate the need for women's only housing;
- case conferences have been useful;
- housing staff are asking for more training on first stage trauma treatment;
- examples of challenges include women involved in sex work, abusive partners accessing women in residential programs, assaults within the units with the abuser being another client, lack of safety for women in co-ed units.

Rural Mental Health Agency

- 369 women in the database (64 per cent of clients in the database are women);
- 228 women in the database had completed screening history (62 per cent of women in the database were screened).
- Of the women in the database with completed screening history:
 - 43 per cent have experienced childhood trauma in the past;
 - 34 per cent have experienced verbal aggression in the past;
 - 49 per cent have experienced physical assault in the past;
 - 26 per cent have experienced sexual assault in the past;
 - 22 per cent have experienced childhood sexual assault;
 - 15 per cent are currently experiencing verbal aggression;
 - 4 per cent are currently experiencing physical assault;
 - 1 per cent are currently experiencing sexual assault.

Monitoring

Introduction to Screening

On an ongoing basis, the Project Coordinator provided support and collected feedback from staff in the partnering mental health and addictions agencies. Staff were provided opportunities to discuss the process of implementing woman abuse screening. When considered in the context of the qualitative evaluation presented in the next chapter, these mid-way reflections are useful to illustrate the learning and professional development process of front line staff from agencies implementing the screening protocol.

Many staff members acknowledged their initial apprehension about beginning to use the woman abuse screening form:

I had initial hesitation with the form. The process was good except the first day I was given the form. I thought I was not trained to fill it out.

I think we all had questions once we started using the form. I am struggling with it still at times.

I had initial hesitation about the process in which it was introduced to us. It takes more practice.

Some staff quickly became comfortable with the new forms:

There are not many problems with filling out the forms.

The form was introduced in a way that facilitated participation from everyone. I had no problems.

Others found it more difficult to integrate them into their practice:

I'm under time pressures. I need more time for assessment. It depends where the client is at.

I am still confused about how often it is that I need to fill out a woman abuse screening form. I am still confused!

One of the most significant challenges was to provide enough training to mental health and addictions staff to enable them to feel comfortable when women did disclose:

We haven't received specific training for sexual abuse.

A lot of us have not received specific training on sexual abuse issues. We need to have someone available; to have a liaison would be important.

Give us something practical. I'd rather have another full training day. We've got to have a whole day.

Comfort in Asking the Question

The comfort level for asking about abuse varied between staff and changed over time as well. Many staff expressed their initial misgivings about the screening:

You don't want to seem like your prying

It's not so easy approaching asking the question of abuse.

These are intimate issues that have been suppressed for years.

It feels like I am asking someone to undress.

I ask myself, did I bring something up that I shouldn't have? Did I force this from her?

Not everyone wants to talk about the secrets.

I was asked at the health unit about abuse. I know how it felt for me. I can only imagine how it feels to be asked the question.

I am afraid that my rapport with the client has been set back.

Not every appointment is the occasion to ask those question –especially if a client is in crisis.

It depends on amount of rapport I have with a client.

With me it is different as a man asking I might be perceived in a different way. It doesn't mean I don't have the compassion but it is not so easy for me.

I'd feel better if there was a modified screening for the initial assessment.

Culture plays a role. In my culture abuse is not asked about and disclosure does not happen with a stranger.

Staff did appreciate the assistance of the Project Coordinator, who acted as both a consultant and mentor. They gratefully acknowledged the assistance they received:

It was introduced in a comfortable way. I liked that [the Project Coordinator] was actually at the office. It is one of the few forms that we are currently using that we actually received training on and were not just given it to fill it out.

Everyone participated in using the forms- the Project Coordinator was available to assist with the forms.

This is one of the few that we have received training on.

It was helpful to have someone available to respond to those questions.

Staff also discussed the occasions when they felt more comfortable screening for woman abuse:

You go deep with women that you are familiar with.

I leave it towards the end of the interview. It depends on how the person presents at the assessment. I go through risk factors questions to get a feel for how they feel. I look for verbal and non-verbal cues.

I started to give the form out to the person and then ask, how comfortable are you with these questions? I feel more comfortable doing it that way.

It depends on the client- some disclose right away.

It was comforting to know everyone was being asked.

The emphasis is not to pull out the tool. I try to ground the person. I don't go into depth.

Some staff quickly became comfortable with screening:

I don't feel discomfort. It is not hard to find the right time to ask. I just tell them that next week we are not doing anything except completing some paper work because it is what I am required to do.

I find it (the screening) very quick.

I like including institutional abuse and war trauma. It is not recognized enough.

Others went with the process, keeping an open mind;

It will be interesting to see over time what will happen.

Resistance

Sometimes discomfort in asking about abuse did foster resistance:

We have to look at our role as service providers; how relevant are the questions?

We need to figure out our function. We can't do everything.

Just because the service isn't there, doesn't mean we should provide it.

I will not ask about abuse at intake.

It feels too intrusive in the assessment. Assessment depends on engaging the person. I won't necessarily screen on the first time appointment.

Identified Challenges

There were many challenges during the implementation. They are shared here in the hope that others can learn from them, and perhaps address some of them earlier in your implementation process. They are also being shared in the hope that if these challenges arise at other organizations, they will be recognized as 'bumps in the road' that can be successfully navigated and not insurmountable barriers.

It is not necessarily the abuse questions that make it more difficult. It is ensuring that there is follow-up for clients.

Sometimes clients want to engage in therapy around abuse issues.

There is a lack of long-term psychotherapy. It is too expensive.

The problem is that our clients do not see counselors. We get put in the position of therapist because there is no one else.

What is my role? Sometimes it is hard to focus just on the addictions piece when safety is a problem or the presenting problem is so linked to trauma and violence.

We need to prioritize needs of clients.

It's hard not to have our own agenda about whether or not a woman wants to lay charges or leave an abusive partner.

It is frustrating to sit back and watch someone make bad choices. Some people won't ever seek help regarding abuse.

Mental health clients are not always empowered to not answer all the questions.

How can we stop the interview to move the person on to the correct referral centre?

Sometimes the client is so connected to this agency, she doesn't want to move to another agency.

One of my clients had flashbacks when disclosing information to a counsellor at [a woman abuse counselling centre] and explained to me that she became very aggressive.

Not everyone wants to talk about abuse because of the flashbacks.

She told me that she could not continue and I withdrew the questions immediately.

I've run into problems with interagency communication.

It feels like we need to try and get the screening done as opposed to respecting the process.

When we are working with clients with physical disabilities, it is difficult to figure out where to meet the person if safety is a question. It's an option to go with a co-worker or in the community if safety is a concern

Duty to Report - we need more information on this. We have different understandings of when to call about child witnesses to violence. There is one shelter that is calling immediately simply because they know the children have been exposed to violence.

Screening for woman abuse also increases my anxiety levels. I'm going over a checklist in my head about whether or not I have debriefed enough about my cases.

It is important to share these experiences here so that front line workers in the mental health and addictions sectors in the community can prepare for the difficult moments. Don't feel alone when confronted with a sense of inadequacy when women disclose abuse. It is normal. The disclosures received are overwhelming stories of betrayal. Simple explanations cannot be offered. There are no quick fixes. Learning to listen is the first step, even when it is difficult:

I felt inadequate after a disclosure that I was not expecting.

I met with this client and she made no indication to me that she had any indication of sexual abuse so I introduced the form and oh my was I ever not prepared for what I heard. I opened up this whole can of worms and she told me that she was not comfortable talking about this and she told me that she hadn't shared it with anybody and I really felt like I had cornered her when I brought it up. It was not a good move on my part, but she had never disclosed it to me and I had been working with her for two years.

That happened to me too. I had been working with this client for two and a half years and I brought up the screening and she asked what are you doing? She said, 'what is this form? I don't want to talk about this form.' I felt so bad. But I felt I had to. Then I really felt inadequate trying to handle the situation. I didn't feel properly prepared. It took me by total surprise and then I didn't know how to handle the situation.

Tools and Tips for Front-Line Workers

Front line staff worked with the Project Coordinator to identify resources and interventions that had worked well as they began implementing the screening protocol;

- Be familiar with the tools developed by the project, including:
 - The Woman Abuse Screening Form - to be used as a clinical tool to assess a woman's safety and related mental health issues;
 - The Safety Plan- to be utilized with all women who report experiencing abuse and can also be used to assess staff safety both in the workplace and when out in the community visiting women;
 - The list of woman abuse and abuse-related trauma services in the community that are resources for women.
- Keep the following material easily accessible and available for staff use:
 - The Woman Abuse Screening Form
 - An updated list of resources for women and their families
 - The Standardized Safety Plan
 - The Power and Control Wheel
- Be familiar with 'Duty to Report' expectations and procedures if a woman discloses her children are being exposed to woman abuse.
- Use grounding techniques.
- Help women to reframe their "symptoms" as "coping strategies" and help them to understand that dissociation, emotional numbing and self-harm are ways of adapting and coping with the overwhelming effects of woman abuse and abuse-related trauma:
 - assist women in thinking about their reactions to trauma as "normal not crazy;"
 - mental health staff often practice within a system that supports pathologizing women's responses to trauma. By normalizing women's responses to abuse and trauma, mental health staff can counter the tendency to label women as mentally ill.
- Recognize and identify post-traumatic stress reactions.
 - Lori Haskell's *Bridging Responses* booklet, 2001 is an excellent resource.

Adapting to Ask the Question

Staff talked about the ways they adapted their practice to accommodate woman abuse screening:

I do not usually use the power and control wheel. I use the model for healthy relationships as well. It's a good meat and potatoes tool and is practical to use.

We have a look at the wheel. It provides a tool for people when I'm asking the questions.

Clients have been marginalized since day one, so they don't define abuse similar to the power and control wheel. I pick it apart from the aspect of safety.

I had to stop and slow down. I needed to space out my screening.

I split up asking the questions over a few sessions.

I needed to let the timeline go. There is always more pressure to do something new.

You almost have to set a time for asking about abuse because it seems like every appointment you have a task to accomplish like taking them to appointments or dealing with crisis.

I spend lots of time recording data.

I hand out information on woman abuse at intake and assessment.

If the person is unsafe then I give referrals.

I use the explanation of form 14's to explain confidentiality policy.

When male staff interview women they ask if the client prefers a female worker.

There were no indicators of abuse, therefore I didn't ask as many questions about abuse.

It's a very individual approach.

Asking is Important

Even as staff struggled with the new challenges of implementing woman abuse screening, many recognized early on that it is important:

Screening should be part of the protocol in mental health.

We should train people in this field. We should ask these questions regardless.

It tells staff a lot of information if clients will not answer the questions.

We are usually dealing with past abuse. I have noticed the importance of screening. The longer I listen to the stories, the more I see the connections between abuse and mental health.

Most personality disorders stem from trauma.

All of the women on my caseload have suffered abuse.

I have been seeing her for over two years and she never disclosed. I didn't know. Her depression makes total sense to me now.

We say to women that it is an invitation to talk, or to take action.

The longer I listen to stories (about abuse) that I didn't know before the more I start to make links between their trauma and their mental illness. Absolutely it is a great impact on her life.

I'd like to see it done over the entire agency. Why not for all clients?

It needs to be reinforced by management. Things get prioritized, there should be regular mentions of the woman abuse.

Taking Care of Staff

Vicarious trauma is discussed on page 41. Vicarious trauma is a reality for those who work with abused women. It is important that agencies provide support for their staff to address vicarious trauma. The comments below offer some suggestions on how to do this:

Case review is an opportunity to discuss vicarious trauma.

Staff meetings include personal check-ins.

It helps to have a fun staff who are very supportive.

The case reviews that occur every Tuesday for one hour are separate. Coworkers recognize that this is a safe time to disclose their issues with clients.

There is also formal supervision that occurs on top of staff meetings and case reviews.

Management advocates for workers to engage in their own therapy. Our schedules are accommodated to make such appointments.

The increased focus on safety for clients also raises awareness of safety concerns for staff:

You are also assessing your own safety when a client discloses. I'm more hyper-vigilant.

It's more acceptable to express when you are not feeling safe.

Expanding Woman Abuse Screening

As a result of implementing the woman abuse screening protocol, several agencies also began screening males for abuse-related trauma. The number of males who access mental health and addictions agencies and who identified as childhood survivors of abuse highlights a need to explore this issue further. The recommendation to staff involved

with woman abuse screening is to receive training on male survivor issues before asking men questions related to abuse.

Lessons Learned

In monitoring the early stages of the implementation of the woman abuse screening protocol, the Project Coordinator was able to identify gaps in training and supervision practices. Work was initiated with agency managers and front line staff to address the following gaps:

- The need for more training regarding the impact of children exposed to woman abuse. An intake supervisor at the local child welfare agency was able to provide in-kind consultation services to staff. This helped all sectors to provide a better response in situations where a staff member was faced with a duty to report that a child had been exposed to woman abuse.
- The need for more training to ensure that mental health and addiction staff have updated information on woman abuse referral information for women. A more closely connected referral network helped to reduce barriers for women accessing services within the three sectors.
- The need to conduct a needs assessment to ensure adequate supervision practices are in place prior to implementing woman abuse screening. Throughout the project, the coordinator addressed issues related to staff disclosing their own experiences of current or past woman abuse. There was a need for a more structured supervision time in order for staff to debrief when a woman disclosed abuse to discuss safety issues related to the job, to receive overall support when experiencing vicarious trauma and to address the staff members own experiences of woman abuse and abuse-related trauma.
- A formal policy regarding interagency sharing of information about disclosure(s) of abuse is needed. It is expected that interagency program communication will increase due to the number of women being asked about woman abuse.
- A designated management person is required to take responsibility for reviewing the woman abuse screening forms in order to review clinical issues related to documented abuse disclosures.
 - For example, if abuse is disclosed then an appropriate note would be: ‘Client disclosed that she had been sexually abused by her paternal uncle between the ages of 6 to 12,’ as opposed to, ‘Client was abused by her paternal uncle between the ages of 6 to 12.’
 - When a referral is given to a woman and she declines to access the suggested resources, then it is appropriate to document that the referral was given. However, staff should take caution when writing a note indicating that a woman has declined a service. For example, a note should not read: Client is non-compliant about accessing the women’s shelter. The legal ramifications of this note could be detrimental to a woman who is involved with the court system (custody/access dispute).

Looking Back: Moving Forward A Qualitative Evaluation.

The Ontario Trillium Foundation (OTF) funded the project to implement a woman abuse screening protocol in mental health and addictions agencies in London, Ontario for two years. The information presented in the preceding pages documents that process. The OTF then provided additional funding for the writing, production and dissemination of this manual. A website has been created to ensure the manual and other resources produced by the Women's Mental Health and Addictions Action and Research Coalition are easily accessible in electronic format. The website address is www.wmhaarc.ca. We invite you to visit it.

What follows is a qualitative evaluation of the implementation of the woman abuse screening protocol in the community. It is written largely in the words of those who have been participating in the implementation, whether from a management perspective, a front line perspective and/or an organizing perspective. The voices of women who use mental health and addiction services are also included.

Data was collected for this evaluation through seven interviews and three focus groups. The interview guide and focus group questions are available in Appendix VI.

The Management Perspective

Implementing Screening

Managers from each of the participating mental health and addiction services agencies were interviewed about their experiences in implementing the woman abuse screening protocol. All of these agencies are still using the protocol. Some had implemented it exactly as it was developed, while others made modifications to fit their agency needs.

For the vast majority of these agencies, it has been completely integrated it into their regular practice:

We have implemented the screening protocol. The tools provided were helpful.

We are still doing screening, we have not made modifications; we use it just the way it was developed.

We are still doing woman abuse screening. Intake is centralized through [agency A.] Woman abuse screening is often done by [agency A] and is indicated on the electronic record. If it has not been done when a client comes to this agency, an individual case manager will do it. We would like to standardize the abuse screening protocol throughout the whole system; make it part of the job, get it well integrated into the process. It is integrated in each area, but we would like over all agency integration.

We are still using the screening protocol. We have made modifications; we have simplified it so that it works better for our agency. Our assessment package is huge and we needed to scale it down a bit. The tools are helpful. They are directly helpful for clients and they serve as a guide and reminder for staff what they are doing and why.

We are still doing woman abuse screening. We have adopted the form that was developed through the screening protocol project. All of the information is there on one page. It is on the data system.

We have made modifications to the screening protocol tool. We have a modified health screening tool that is part of a mandated assessment package for Ministry of Health funded agencies. We have embedded abuse screening in that for every client, male and female. It has been effective.

Yes, we are still screening for woman abuse. We had been doing it prior to the project. For us it wasn't revolutionary, we revamped our process to fit with the project. We made changes to fit better with the protocol of project and to be part of the process.

The change is that we adopted forms from the screening protocol that a staff member fills out at intake. The abuse history is highlighted for the caseworker.

The tools have been effective. Initially when the agency received training with the project coordinator we did make some modifications to the tool to fit our protocols and mandate. We did not change the core intention of tool.

It has been integrated into our system. That is important because otherwise it would be overlooked.

Only one agency, a mental health crisis service was not consistently implementing the protocol. They explained this was due to the nature of their crisis work:

We do screening in the Emergency Department at [the hospital]; it fits in well there. We have a mental health crisis nurse who works in the Emergency Department. She is the designated person in charge of screening. Screening was new for her. Where warranted, we would use it.

We do it here if it appears to be indicated. It is not a routine part of our crisis service. We made it clear in the beginning that we had a problem with it. If it is not indicated it could be inappropriate and an inadvertent trigger. Because the crisis someone is calling about may be completely unrelated to woman abuse, to bring it in and not focus on the current situation, may escalate the crisis.

Even those agencies that had been screening for woman abuse prior to the introduction of this protocol indicated that it had helped them to be more effective:

It has been very effective, absolutely! We screen every woman going through for an assessment, and every woman going into a community support program. It helps us to determine which community support program is the best fit.

When our assessment process changed, it changed the structure of the interview process. Abuse was covered before, but now it is more visible. The protocol makes sure that questions are asked.

The tools are helpful in terms of making referrals or educating women. In the past, many had ongoing support and were never asked about abuse in any depth.

The agency was doing a good job, but our work on addressing abuse was not as structured as it is now.

It has been effective. It is really important. We were doing it prior to the project. Our intake counsellor is experienced and knows a lot, but staff have different levels of expertise and things might get missed if we don't specifically ask questions.

It is effective in that it has helped to identify women with abuse histories, but because of the nature of crisis work, we don't do therapy. But it helps to refer forward.

Staff Orientation/Training/ Supervision

Managers of the agencies discussed how their staff were oriented and trained to use the woman abuse screening protocol. They demonstrate a great deal of commitment to implementing the protocol through their training initiatives:

Training for new staff is ongoing and every new staff member gets it. We have a checklist for training that all staff need to complete as part of their orientation. Because abuse screening is embedded in the assessment tool, it is something all new staff are trained on, it is a standardized piece. Training increases the follow through.

Staff are trained on screening when they are hired. Training is more intensive for people doing assessment. All staff have been trained and this is ongoing.

New employees are very aware of the screening protocol. We have had staff to support the program; we have taken a lead on that. It is most relevant for assessment staff. Perhaps if we were larger it would be a more significant challenge to train everyone. We continue to have a designated person responsible for ensuring that staff are trained and the screening protocol is implemented.

Initial training was a requirement for all staff . The bulk of the training in terms of philosophy and historical issues was a one-time event, but we have a goal to continue to provide ongoing training on the implementation.

We have three trainers in the case management program. [Our agency] made a commitment to have all staff trained in the philosophy of woman abuse and how to use the protocol. Each program had a staff assigned as a trainer or had a staff volunteer as a trainer. The case management program has standardized use of the tool.

We have a policy that within their first three months of work, two of three trainers will provide training to new staff, on the orientation procedures. We set up a procedure to deliver this training through two one-hour sessions. We have a training manual that we developed. The new employee must read the manual before training. We took the original guidebook and adapted it. The content is similar, but screening for abuse in a housing setting is different from a social-recreational or a case management setting.

The screening tool is pretty easy to administer. We do ongoing in-depth pre-screening workshops where we look at the Power and Control Wheel. Staff need to understand how deep seated and complex this is, and they need very in-depth training. That helps people deal with this piece.

New employees are made aware of screening. The intake worker supports staff to do screening and sometimes I do too. There is also S. who has implemented it in

the computer system. We don't have one designated person, but a person in each program area.

All frontline staff had training during the project. Two people went through train-the-trainer. That helped give them the ability to assist staff. One did a training session with community mental health services, both woman and men staff. Since then we have not had a formal training, but it is part of our orientation.

Managers also discussed how training was supported through supervision and case conferencing:

New employees are aware of the need to screen for abuse and there are ongoing opportunities for case conferencing to discuss these issues as well as supervision. The supervision has to be ongoing. Case conferencing is critical if there are concerns about abuse or safety issues. This is covered through our policy and procedure as part of ethical practice, but is my job to make sure they do that. Recently, I did a file review. If the box for safety planning was not ticked off, I discussed it with the staff person. It is a clinical practice that is monitored.

We are now aware of issues that may come up around asking [about abuse.] In the past, we may have assumed that staff would be aware, and we did not help them to get training, and reading materials. Now we do provide this. That's a change in supervision practices. Supervisors got training from the project.

Generally, new staff receive an introduction to the safety plan and to the screening protocol. This is not a one-time training event as it is woven through practice and supervision. It is both part of orientation and then broached thorough supervision and case summary/management meetings.

Some managers made the point that existing supervision practices also supported the implementation of the protocol:

We have not made changes in supervision practices, we have always been aware of the emotional and physical costs of doing this work. Support for staff dealing with clients who experience woman abuse was already integrated in the service. It's very important, fundamental. Safety has to come first before we can do any of our other work. I am the person designated to provide this support and this will be sustained through my position. I was involved in the supervisor training. Self and peer education is ongoing.

We have not changed supervision practices. We have always been sensitive to trauma and aware that when a client is in crisis, that could be the source of it. All supervisors were trained together and we haven't had a turnover that affects this program.

None of the managers indicated that the significant commitments to orientation and training, as well as follow-up supervision and case conferencing had caused financial hardship for their agency. The initial training offered through the project helped to keep training costs to a minimum:

All front line staff were trained by the screening protocol project.

Staff received one time training from seminars offered through the project. There were no extra costs to us for training.

We don't notice extra costs for this training. The cost to us would be time, but because it is integrated in our orientation and ongoing training, there is no drain.

We have staff that have come on board since then, and we do talk about screening every few months to review the process. No training costs were incurred; we just used what has been offered by project.

There have not been any outstanding costs for staff training. Training has already been built into the budget and this is absorbed there. It becomes another core area of training. The biggest cost is around staff time.

We are able to absorb training costs in our regular training. We were doing that training anyway.

There is no budget to train on screening, but it is incorporated in regular training and assessment procedures. I can't say what the training costs because it is incorporated into existing budgets; it happens on a continuous basis. Because we have integrated woman abuse screening into our programming, we don't see the costs as add-ons, just part of what we do.

The need for more training and ongoing training was a consistent theme:

We need ongoing training about legalities, and updates on thinking and new research. We are committed to have this work continue as staff turns over.

Our supervisor was trained by the project. We could train a replacement supervisor. The training could include case studies involving woman abuse and substance abuse for interviews.

Ongoing training is important, especially for new staff, reminding, brushing up on skills.

More training and refreshers would be useful.

Some agencies indicated an ability to cover the costs of additional training:

Broader training refreshers would be a cost to the agency, but this is not a major issue from budget point of view.

We do have a budget for annual training.

Other agencies however, expressed a need for more resources to support further training:

We could use more resources for initial overall training. Other agencies that don't have such a cohesive system or budget for training could really use this.

A lack of funding though, did not preclude taking advantage of low cost training opportunities:

We have very limited money for staff training, so try to make use of community workshops. We take full advantage of any community workshops.

As relevant workshops are offered, we send staff.

As workshops come up related to addictions, mental health and woman abuse, we send staff.

We make opportunities for staff to attend workshops happening in community and this allows them to continue their learning and to bring back the latest information.

Policies and Procedures/ Hiring/ Internal communications

Managers were able to implement a woman abuse screening protocol in their agencies without significant changes to their policies or procedures. Although the project enabled a more systematic approach to screening, existing agency policies did provide an adequate framework for screening:

Policies or procedures did not change because it was part of what we were doing. The implementation has been quite seamless.

We had no policy or procedure changes because an awareness of abuse was a built in from the get go.

We have not changed policy because our previous policy was that everyone would be asked about abuse at intake. Our computer program leads the intake worker through the process.

In one case, although policy changes were not needed, there were changes to procedure:

While actual agency policies haven't changed, guidelines and processes for doing the work have been added. For example, it is now incorporated into the annual

review, and it wasn't there before. The policy says that new employee will receive training. Now our designated trainers will take care of education on woman abuse

Another manager flagged the possibility of upcoming changes:

Policies and procedures have not changed as a result of implementing the screening but we are in the midst of a review and if changes are needed, they will be made. Nothing is formally mentioned in policies and procedures, but there is a section on screening in the orientation manual.

In most cases, changes to job descriptions and hiring practices were minimal or not needed:

There have been no changes to job descriptions.

We have had no job description changes and no hiring practice changes. We have always hired specifically for people familiar with woman abuse.

Hiring practices have not changed, understanding trauma has always been a focus, but now we are now more organized about it.

There is not a specific notation in job descriptions. Hiring practices have not changed, but a question is often asked in relation to trauma and abuse. An understanding of these issues will be noted as an asset. There is more heightened awareness in the agency.

There have been no job description changes. No hiring practices have changed. New employees become aware of screening through the orientation processes.

Hiring practices have not changed, but we were very sensitive to woman abuse even before the project. Many staff have backgrounds in women's agencies.

One agency was contemplating a change in job descriptions if the statistics being collected supported it:

It is not part of job descriptions, but these are also being considered as part of the organizational review. There is one line that talks about experience in trauma being an asset. Whether or not we change job description depends on the stats collected.

The most significant changes occurred in the area of internal communications:

Internal communications have changed as a result of implementing the screening protocol. It has been the key reason for revising our assessment tools. By including trauma, we altered what we need to know from a woman's assessment. We talk about abuse a lot more now.

Integrating the form into the internal database has changed internal communications. Now woman abuse will come up as a topic of discussion on committees overseeing program areas.

There is more awareness in our internal communications. If someone is in housing, they will hear that behaviour might be related to trauma rather than a mental health diagnosis. It also informs decisions about placements for permanent housing, i.e., whether or not to put a woman with men.

Another issue is communication, how we communicate any new disclosure of abuse. Right now, it happens via e-mail or telephone. Eventually we will have electronic documentation.

Clearly implementing the woman abuse screening protocol opened up space for many internal discussions of woman abuse. In two cases, there were not significant changes to the way staff communicated inside the agency. This is likely attributable to the fact that woman abuse was already being discussed:

Internal communications have not changed. Nothing other than the specific training on the tool has been communicated differently.

Internal communications have not changed because violence against women awareness has been with [this agency] since the beginning.

Board of Directors

Implementing the woman abuse screening protocol did not require changes in agency policies and therefore, the Board of Directors was not directly involved in the process. Some staff consulted with the Board before implementation and were given the Board's approval:

Our Board of Directors was informed about the screening protocol when we first began the work. The Board doesn't get specific information, but they get a package that includes information on the protocol. The screening protocol went to the board for approval.

Sometimes the organizational structures did not necessitate involvement from the Board of Directors:

We don't have a board of directors, we have a management team. This doesn't impact them, it is a clinical decision, so I am in charge of that.

Regardless of the degree of involvement, there was agreement that a summary information package about implementing the woman abuse screening protocol would be useful:

It would be useful to develop a one-page report highlighting the screening protocol, congratulating the agency for training X number of staff, and recognizing it as an agency that has received training and is providing greater safety for women and children. It would be most helpful for members of the board of directors. Board members rarely read more than one page.

An information package would be useful, the more information they have, the better aware they will be.

Data Collection

Some agencies had formalized procedures for data collection and saw this as an important component of woman abuse screening:

Front line and administrative staff have responsibility for data collection. There were no administrative challenges to collecting woman abuse screening data. We modified the provincial screening form. The goal would be to make what is embedded in our system now province wide.

General data is collected at intake and added to by caseworkers. I process monthly and yearly information.

Data is being collected. S. the Administrative Assistant looks after the database for whole agency. We are not pulling reports right now; we may want to look at that. The potential is there. The intake person collects it, or sometimes, as the Team Leader for the community support program I do. Usually people come through intake, but if someone has been in a community program and is coming back or coming from another agency, she may skip intake and come straight to community support.

We had a data specialist in the initial two years. Data was collated. We still continue to do screening, but we are not running reports. There is no concern that they aren't being done.

Other agencies had much less formalized systems of data collection:

We are collecting data, but really is in the files, it's not external. Each staff collects on a case-by-case basis. There is no summarizing or analyzing.

We face administrative challenges. We don't have a database to support data collection or anyone to do data entry.

We are not specifically collecting this data; we don't break it down to this level of detail. It is all included in normal screening. That type of information is important, but just one piece of a lot of information that flows back and forth.

We are not currently tracking data from the screening. We did with the project, just to see, and stats were shared with committee. We do keep information on referral sources.

However, even informal data collection was regarded as important:

Because we haven't analyzed our data, we plan with awareness, but not with numbers. Program planning and safety planning for the agency is based on this awareness.

Data that is collected was used for a variety of purposes:

All data collected is being summarized and analyzed and is used for planning.

Stats around presenting problems are reviewed annually. We use it for letters of support, for planning, and to share with the program committee of the board of directors.

In some cases, managers were still speculating on how they could use the data they collect:

We don't know what we want to do, the screening could help with future planning and budgeting. I don't know if we want to do further analysis to request further funding for this area.

We could request staff with specific training if we could document the need. It is really hard to access long-term counselling. Getting access to that could be very helpful.

Impact on Staff

Managers discussed how their staff had overcome their initial reservations about implementing woman abuse screening. Consultation and support, from peers and from leadership are named as an important part of the process:

In the beginning, there were some reservations about implementing the screening protocol from staff, but now we don't hear about it very much. It is now the norm to use the screening protocol. We have regular peer consultation and support; that is part of our norm.

Initially everyone was concerned about the time and could we do it properly. After that, everyone was on board, including the support staff that had to input data. We had support, including from the CEO for the implementation.

The other concern was, 'where will we refer?' Out of that, we have built some strong partnerships. Staff are not trained to do counselling. There was some concern about knowing how to respond and if a person wants to do more

counselling, how to redirect. [A woman abuse counsellor] has done some training. An important outcome is the building of relationships.

We do peer support on an individual level and in team meetings. We talk about our struggles with the work, like recognizing what we see as abuse, and how to make good referrals and waiting lists.

One manager, who did not perceive an impact on staff, still mentioned the importance of peer consultation and support:

There has not been an impact on staff because this was something we did before. Information would be gathered through a more general question about receiving treatment from a community service provider. Sometimes you do forget to ask pieces. Based on anecdotal feedback there is a high percent of abuse disclosures since the assessment has been standardized. Peer consultation and peer support is regular.

Positive benefits for staff and management were noted:

The person who was designated to be on the committee got a lot out of it. It gives one staff specialized knowledge and that helps to get buy in for other staff.

Just being involved with someone from the violence against women sector makes abuse become a bigger part of my consciousness. It becomes more part of my work with my staff. There is more collaboration.

It has changed a lot for me personally.

The staff as a whole are more comfortable when someone talks about abuse. We did have this question on our old assessment form and I would think, 'I hope they don't say yes, I don't know what to do.' I would kind of skirt over that. It wasn't born of a desire not want to help, but of a lack of knowledge. I really believe it has helped us to provide better services.

The new tools were not a lot different from what we were doing, but it reassured staff that we are doing the right thing. We need to be generalists to serve a great variety of needs, so this has debunked the myth that there is a golden answer. Experts are doing the same things we are doing. It was reaffirming.

When queried about whether or not staff were experiencing more vicarious trauma as a result of implementing woman abuse screening, there were varied responses. Some managers did not feel this was a problem:

I don't think that there has been an impact on staff, because we have been asking questions all along. It is helpful to be more aware of vicarious trauma. We are fortunate here because we do have a lot of time built in to connect, to talk about

clients and how they have impacted us. And we can talk to the psychologist. That kind of support is built in here. There are lots of people I can talk to. Maybe it would be more difficult in smaller agencies.

There has been no increase in vicarious trauma for staff. We spend a lot of time talking about that and dealing with compassion fatigue. It comes with the whole area of crisis, so our existing procedures accommodate for that. Peer support is regular with staff.

I don't know of an increase in vicarious trauma for our staff. We do talk about it in the training, and sometimes someone will talk about an incident that seems close to them. We do encourage people if they are feeling they need to talk to someone to contact the EAP program or whoever they trust in the agency. The point is that we encourage staff to deal with vicarious trauma. It is normal. We tell staff, look after yourself, go to counselling or do yoga, whatever you need. We also talk about not knowing that the stories affect us.

Other managers did feel that vicarious trauma was a risk for staff, whether they admitted it or not:

Staff are impacted by vicarious trauma but they claim otherwise. Fatigue and the inability to wind down are common effects. Staff have peer consultation and peer support formally and informally on a regular basis.

Staff do experience vicarious trauma and [a trauma counsellor] did come in to do a workshop for staff. That was helpful for staff to get the big picture. We have an EAP program and encourage staff to access it to keep themselves healthy. They have a fairly high level of trauma exposure, not just related to abuse, because this is a crisis service. Staff do peer support and consultation. Two managers have been trained in vicarious trauma debriefing, and once a month we have a break away day where we do some training and some sharing. We use it as a collective time to break away from the work and talk about issues. We have a weekly case review, and any staff can participate.

Whether or not they perceived an increase in vicarious trauma, managers consistently discussed the importance of building in support mechanisms for staff to address this issue. It is a reality for everyone exposed to woman abuse and abuse-related trauma.

Meeting Barriers and Challenges

One insightful manager noted that before the logistical challenges of implementing the woman abuse screening protocol can be addressed, staff must become comfortable with the subject of woman abuse:

Abuse is still a taboo and we need some time to process information about it. It is helpful for management to encourage more general discussion among staff before the training starts.

If this important step is not realized, resistance may develop. One manager noted such resistance:

There is a bit of an attitude that we are getting too feminist.

Yet, it is important that those agencies whose core mandate is not woman abuse, be aware when it is part of a woman's issue. Another manager articulated this:

Woman abuse is not our mandate, but we are very sensitive to the fact that this is an issue that our clients are dealing with. We are finding increasingly challenging situations.

Managers acknowledged that implementing the woman abuse screening protocol was a demanding process:

It is always time consuming to add something new to your practice and training staff to input the data has been work.

How easy it will be to implement the screening protocol depends on the agency's experience, existing policies and procedures and expertise in this area. It was a very rigorous process.

There was a general acknowledgement that woman abuse screening was being implemented in agencies that have many competing demands:

Lack of time is a barrier in this work and the fact that there are always other pressing issues. When people come in and they are psychotic or in extreme crisis, or when we only see people briefly, it is difficult. If people are quite ill, it may not be possible to ask them.

We have competing urgencies. Client needs and agency demands on our time are challenges that have to be met in implementing the screening protocol.

It needs to be tailored to fit with what the agency has. Maybe there are phases or aspects to implementation based on what is currently happening. If an agency has good policies and procedures, maybe they can be tailored.

Some managers found it helpful to part of the planning process:

It is helpful to know ahead of time what to expect and being on the committee gave the process a natural flow; there were no surprises for us.

Others found the commitment to be part of the planning process too time-consuming:

At some point, our staff rep stepped off the [planning] committee because our mandate is to serve.

Those who were part of the planning process were able to engage with some of the difficult questions that arose. How the work would be sustained is certainly one of those questions:

There have been workload concerns. There is lots of paperwork, but what is the sustainability? There wasn't initially a lot of dialogue about that. Would it sit in the file someplace?

Managers were able to make several suggestions for meeting staff needs in the implementation process:

What is helpful for front line staff is not the same as for management. They don't need the administrative detail that goes with management.

Tracking stats at the beginning of implementation is helpful because it gets the individual workers thinking about what they are doing. If you don't have the buy in, it doesn't go anywhere.

Every staff person needs something at their desk that they can refer to.

The ability to find immediate support for a woman who has disclosed abuse was a constant concern:

If we can't get a woman to a service quickly, if we can't address her immediate need, it probably won't happen. They live in such a cycle of crisis, the next crisis will take over.

There is the common problem of waiting lists once we make a referral.

The discouraging part is that we were hoping to get easier access to specialized resources or at least gain the comfort of knowing if a woman is ready to work on her issues, there is someplace for her to go. It is still not easy for clients to access service or break down barriers. [A woman abuse counselling agency] will now come on site. This is helpful.

Occasionally questions arose around providing screening for men as well as women:

This is dealing specifically with abuse against women and we are finding that there are also male clients. Are there different protocols for men? Should we be addressing it with all clients? We do use the safety plan for men. We do not use the protocol form for men, but we do document. When we document abuse, we document it separately from other issues.

At the same time, there was recognition that beyond the greater prevalence of abuse in women's lives, how they experience abuse is particular to their gender:

We don't want to exclude anyone, but I believe from all my experience that there is a significant difference for women in experience and internalization.

The management of one agency continued to have concerns about implementing woman abuse screening when addressing the needs of women in crisis. They addressed this by modifying the screening protocol:

Our team met with the project coordinator and the planning committee. We talked about woman abuse screening from a crisis perspective. Abuse may not have been the precipitant for the current crisis and a woman may not be ready to deal with it. In its purest form, the woman abuse screening protocol is not appropriate for a crisis service, hence some of the modifications we have made.

The Impact of the Woman Abuse Screening Protocol on the Way Work is Done

The mental health and addictions agencies implementing the woman abuse screening protocol started with varied levels of awareness of woman abuse and with varied relationships to the violence against women sector. Those who had the greatest level of knowledge and the strongest relationships felt the impact of implementation the least:

We do make every effort to refer to appropriate support. We are not making more referrals, we just have a different way of capturing them. It didn't impact our practice, if abuse was indicated, we would ask about it anyway. We would ask if they wanted support.

Because representatives from the violence against women sector helped to build the service from the ground up, there were no surprises for the agency in implementing the screening protocol.

Some managers reported that implementing woman abuse screening enhanced their services, but did not alter them significantly:

Abuse screening has not really had an impact on planning. The agency is functioning at maximum capacity and we can't create new programs. Any training that looks at women's issues augments the care women get individually and in group.

There were no surprises in the implementation process, rather it was more a validation that we were doing the right things. We saw that we could adopt a better system to make sure abuse was routinely investigated. That makes the service better.

I know that we are dealing with more broad spectrum issues, but it is important to pay attention to woman abuse. It doesn't hurt to be asking more.

Others acknowledged that the screening protocol had a significantly impact on their work:

Over the last year, we have seen a lot more attention to trauma and abuse. The question is asked more. We have a reputation as an agency that continues to screen for abuse. We do receive clients with a PTSD diagnosis. We are seen as an appropriate place to refer these women. This can be a challenge because it is a different client profile. It does change how we deliver services. We are still looking at how this will impact how we deliver services. We have done some trauma training with all of the staff. This is an area that needs more training.

The screening protocol has had an impact on the service we offer. In the past, we would briefly touch on abuse, but now we look at it much more in-depth, and we can address needs better; we can refer to the appropriate community support program.

We have been tracking whether or not numbers have changed because we were asking the question previously. Our way of asking has changed. Asking the question does make a difference for clients. Because we are not known as a woman abuse shelter, women would come here because they aren't ready to deal with that yet. You may know that one of the core issues is violence, part of where the person needs to go, but they are not ready yet. Asking the question will bring it to the forefront and even if they say no, they will know that there is a place to talk about it. Also it lets us provide appropriate referrals.

It makes a difference too if someone does say yes. We do the safety plan and that is not something we were doing formally at intake.

Whether the changes made to the way agencies operate were minimal or significant, those involved in the project agreed overwhelmingly that women had benefited. There was appreciation that the woman abuse screening protocol had been developed thoughtfully and with an ongoing process to support implementation:

Screening has ensured that questions are asked consistently and the implementation of screening has been done based on best practice.

Managers described an array of specific benefits for women:

In terms of people who matter the most, the women have benefited. We have access to supports. Many people who come to us don't know how to access those supports.

Screening has had an impact on our clients. The number of referrals has increased and we use all of the supporting services. The most important thing is that we have helped women be more knowledgeable about what constitutes abuse. Now

they know, 'I'm not crazy, I'm depressed and there is a reason for it.' It helps us to understand behaviors better.

Has screening had an impact on clients? It has reduced the stigma, universalized the issue, and made it up front and matter of fact. It helps women to access supports more rapidly because we initiate the discussion, they don't have to initiate it. We are exposing and raising awareness for women who might not have considered that as a piece of the puzzle.

Screening has had an impact on the service we offer. In the past, we would briefly touch on abuse, but now we look at it much more in-depth, and we can address needs better; we can refer to the appropriate community support program.

What helps staff, helps clients. We are assured now that clients are not falling through the cracks and if woman abuse is an issue, staff are aware.

Discussions of woman abuse and safety had the unanticipated positive consequence of making the workplace safer for staff as well:

We talk about safety when entering a home. A police officer has talked to us. We are constantly assessing the risk factor as we go into a home.

It has really heightened how we think about abuse and harassment amongst ourselves. We had a previous staff situation [of workplace harassment and bullying]. This information helped us to identify and deal with internal problems. It has been an unintended spin off.

The work to implement a woman abuse screening protocol in mental health and addiction agencies rests on collaborative relationships between agencies in these sectors and those in the violence against women sector. Managers described how these relationships grew and how important they were:

Yes, screening has connected us more with the violence against women sector. We see we have a common goal. Typically, the sectors are isolated, but it is better for the clients if sectors are better connected.

Learning about woman abuse has fostered relationships and relationship building. Screening did get communication and contacts going.

We have a partnership with [a woman abuse counselling agency]. If screening can't take place in a person's home, the woman can come to our agency and a counsellor will come and do counselling. This was a barrier that became known and had to be overcome.

The main change is with [a woman abuse counselling agency] coming on site. That is significant, they really heard that we were out on the margins, and it was

hard to get women service in a timely manner. Now we can be much more sensitive to their needs.

We already had links because of the nature of our service. We have links with most community agencies. It did enhance relationships and we do maintain connections.

There has been more interaction at an informal level with violence against women agencies like [a woman abuse counselling agency] and the [sexual assault counselling agency]. Through the training I came to know more about the services and one or two people I could contact. Sometimes I consult and collaborate on an informal level. A woman abuse counsellor has said that she would provide training.

Our relationship with the violence against women sector has changed. It is more in-depth, it was a theoretical partnership before, now it is more concrete. There is more interaction, support and collaboration. The violence against women sector has invited us to do more in-house training on addictions and parenting. There is a sense of a growing collaboration. The CAS transformational agenda is part of this.

Recommendations

Managers had many recommendations for building on the collaborative work done to implement woman abuse screening within the community. Some of these recommendations are relevant to other communities as well:

In the sector there is a lot of need for training. People in addictions need a lot of woman abuse training.

Have a protocol with [the woman abuse counselling agency], so that a woman can come here for an appointment with a woman abuse counsellor if she has a concern about going there.

I have been connected to the woman abuse agencies, but there is still work to do with the staff as a whole. We need collaborative opportunities for staff to get together with the violence against women sector, particularly frontline staff. We may all know one person from an agency, but we don't know the others. Privacy legislation can prevent us from working together; if we knew each other, we could work together more effectively. It's not even training I'm suggesting, just opportunities to get to know each other.

It would be great if there was a community refresher course every year. Let's share scenarios, hand out a new copy of the resource list, so that all phone numbers are up to date. Let people know about the web site.

We have built a foundation and it can't get lost. The project will keep sensitivity in the forefront of the agency mandate. It's easy for woman abuse to get skipped or missed if the screening isn't formalized.

Although there was almost unanimous agreement that woman abuse screening had led to positive changes for organizations, staff and clients, one manager did sound a note of caution:

I think that screening needs to be thoughtfully implemented. What is the reason the client is coming to your agency? You can't screen just because they are there. Clients may not be ready to disclose, you need to know when to back off or we risk making the situation worse. Well meaning interventions can be ill advised if not appropriately done.

Some recommendations were focused more generally. They will be pertinent to any community that is about to begin implementing a woman abuse screening protocol or even a community that is beginning to think about it:

I would like to see a woman abuse screening protocol implemented across all other branches of this organization. I have been wanting that for a long time. It could make a real difference in understanding trauma for staff in other branches.

I would like to see refresher courses [about woman abuse] offered through agencies across the province.

I would highly recommend woman abuse screening, but training is very important. You can do more harm than good if you are not properly trained.

There is a constant need to reinforce the need to screen, even when we know the importance of it. We get familiar, we make assumptions about how people look or present. By standardizing the screening, we don't tap into our own biases.

It is really key that management has the commitment for the training to be successful, you need buy-in from management down. It needs to be a concentrated training, train everyone all at once. Then make sure there is something in place so that new people get the same exposure.

I would encourage anyone who is not asking questions to ask. If we are working with vulnerable people, it's a no-brainer. It should be part of what we are asking and service providers need to know the resources so that we can refer. You need to be doing this and this is a great tool and an easy way to work through the process with your staff and organization. I would talk to someone in another community.

It is definitely better to be doing screening collectively. It is the same with high risk infants, it's better to be connected to others dealing with the same issues.

Community protocols are very helpful for sharing information, and for developing standard practices. They break down silos instead of building up the walls. Rarely are the people we are dealing with dealing with one issue.

Rating the Woman Abuse Screening Protocol

Managers were asked to rate, on a five point scale with one being poor and five being excellent, how successful they felt the woman abuse screening protocol had been in their agencies.

Ratings ranged from four to five plus. The average rating amongst the agencies involved in implementing the protocol was four and a half.

Two caveats were offered in relation to these ratings:

I offer a caveat. This may be the vicarious trauma piece; we are creating a culture of fear and mistrust of men and partners. We are aiming to reduce risk, yet life is about risks. We have to plan to be safe, but if you can't be where people are and see where they live, you can't understand the context. We need to help women feel confident about their own skills and trust their intuition.

Respecting the above conditions, and with the caveat that I am not an advocate of indiscriminate screening and I am not an advocate of screening if people are not trained to know the implications and do not understand the need to be nonjudgmental. With all that it is important for both women and men.

The qualitative and the quantitative feedback of managers was overwhelmingly supportive of the implementation of a woman abuse screening protocol in their agencies.

A Front Line Perspective

Why Started this Work was Started

The women who were responsible for planning and organizing the project to implement a woman abuse screening protocol in the community reflected on where the work had begun:

In the original Kitchen Table Project, we learned women want us to know, they want us to ask. (see <http://www.wmhaarc.ca/assets/KitchenTableProject.doc> for a copy of the report)

And we learned that they weren't being asked. They had not been asked. Women had never been asked. And in the mental health system they would be misdiagnosed and they had never been asked about trauma. And those of us in the violence against women movement had seen a number of women who had been misdiagnosed, or at least, the trauma hadn't been recognized.

And I think they really suffered because of that, I don't think 'suffered' is too strong a word.

And I think addictions are a coping mechanism, for women who have been abused, often.

A lot of women who have experienced trauma and woman abuse are coming through the back door of addictions because her partner has no idea there is a violence against women counsellor. And that's how they are getting that kind of support because it's the safest way to do it.

It was because of the connection that we wanted to work [together].

And that was the genesis of the Women's Mental Health and Addictions Action Research Coalition (WMHARC.) It was the three sectors all coming together. We all saw the connections.

For me, it wasn't as strong, as relevant as it is now. I knew about the connections, but I didn't put the three together as I would today.

Do you remember when we had [a professor of psychiatry at U.W.O., an associate scientist at the Lawson Health Research Institute and a physician for the London Health Sciences Centre] come and talk about concurrent disorders and she said, "I'm not going to talk about concurrent disorders, I'm going to talk about trauma and where it all starts." I really appreciated that.

I guess I'd want to see in the manual that it's about better assisting the woman and it's about providing the best possible assistance. It's about the client, them being

safer or their children being safer. It's about recognizing how the trauma has impacted them and normalizing the impact of the trauma.

Prior to Implementing Woman Abuse Screening Protocol

Front line workers discussed what they knew about the connections between woman abuse, mental health and addictions before the project:

I had some understanding [of the connections between mental health addictions and trauma], but I don't think I understood how big and vast the learning and the changes would be.

I don't know if understand is the correct word, it's an ongoing thing to learn about the connections between all three.

I guess I would say with what I know now, I didn't understand, I don't think I really understood the real connections; it's been a great benefit to me.

Non-Routine Screening

Screening for woman abuse was not an entirely new concept for front line workers in mental health and addictions agencies. It was the idea of universal screening, or asking the question every time, that was new:

They told us [about being abused.] Or some were asked. It was not a concerted effort, it was probably based on the individual workers experience and background, comfort level maybe. I think there were certainly individual workers, and some organizations, that understood the importance of trauma and asked routinely.

For most workers, it was indicator based. If they saw something, or heard something that would make them think woman abuse, then they would ask. But they weren't asking every woman.

Even five years ago we didn't ask the question, if someone came out and talked about it, then we would talk about it.

I would say overall we didn't know [about woman abuse].

As long as women were not being routinely asked, workers were not always prepared to respond to disclosures:

It's not that it didn't happen, it's how it happened. Before if they said no, that was it. Now we explore what abuse means. If workers did ask, it wasn't in a way that opened up the conversation.

Sometimes we would get that information, but in my case I was terrified if someone disclosed, I can remember our old assessment forms. We would ask that

question, but I can remember being terrified. I knew it was a serious situation with the individual. I wasn't well versed with community supports. It's really quite sad in a way.

And in some cases, although a worker may have recognized that the disclosure about woman abuse was important, others in the system did not:

I remember we did an assessment and I put a lot in about her trauma history and sent it over to the agency where she was receiving support and they called me and said why is all the information on the trauma in there, all we need is the diagnosis.

Screening Begins

Front line workers reflected back on their attitudes towards screening before being trained and prior to implementing the protocol. Many were concerned about an increase in their workload:

I said, 'I'm already working eighty hours a week and now you want me to screen everyone coming through the door?'

Initially I was concerned about workload. I thought, 'why is it necessary?' I don't think in the beginning most of us ever thought there were that many women [who had experienced abuse].

I thought, 'how many issues are we going to deal with in assessment? I was a mental health person; we had a little bit on addictions, but violence against women? I knew nothing.

The workload problem did ease up with time:

I know initially when we had to ask so many in at timeframe it was quite difficult. Now as we ask it's easier.

Other workers expressed concern about whether or not it was appropriate to ask. This concern faded as they realized how many women have experienced abuse:

I'll be the first to admit I didn't think it was appropriate the first time you meet someone.

Dating back, I was one of those people who said, 'this can't happen at assessment.'

I agree I felt the same way. But now, after doing it for months, I feel differently. The number of women who I see on a daily basis, who have been abused is really high.

And where I'm at with assessment, I can't believe how many women disclose and first time disclosures too.

When beginning to screen for woman abuse some workers found that:

The script was helpful to ask, rather than just saying, 'so do you have a history of being abused?' It gave a direction, and helped us to be a little more organized.

Workers found that sharing information with women about why there were being screened was helpful:

I always make it clear that it's a protocol that we ask these questions.

I think the universality of it makes it easier. We tell our clients that we are asking everyone. That sort of takes that shame out of it. The initial reluctance to say anything is taken away by normalizing it.

Some workers, who had both male and female clients, did question whether males should be screened as well:

Some of our staff say, 'why aren't we asking males as well, what is out there for males?' There is some anger, there is so little for males.

The project is going to end with this manual and how are we going to expand this for males?

Some agencies do screen their male clients:

We ask everyone, we ask males as well.

Although males disclose abuse less frequently, the workers found it difficult to make appropriate referrals:

I get a slight response for males. But there is not place to refer them.

Overcoming the initial reluctance and hesitation to ask, workers came to conclude:

I think the screening really invites women to talk about their abuse.

I was thinking about how complex it is. Initially people wonder why we are asking. It's everything. It's like a damn's been opened. It impacts how we might work with the individual. Our job is to try and recognize what someone is initially going through. One day it might be this way and the next day another way. We are very linear and trauma victims are all over the place. It's a normal way to respond to abnormal situations.

What Happens When a Woman Discloses Abuse?

One of the biggest worries that front line workers faced was, what to do if a woman discloses abuse. As caring professionals they knew it was important that the woman receive appropriate service. At the same time, most felt unprepared to offer this specialized support themselves:

I guess I've been a big proponent of screening all along. My concern was once we start getting disclosures; where do we take it? How do we service the women after they've indicated there's been a problem?

We don't want to re-traumatize them, put them in a situation that will make them worse, we want to send them in the right direction to get the care and treatment that they need.

And I think the elephant in the room is that these are incredibly sad stories, there is a whole feeling of helplessness. There are supposed to be so many services. We know there have been many years of carrying the secret of the abuse. And someone finally opens up and there are wait lists.

That was my fear that the wait list was going to continue to grow. There were a couple of instances where I thought, 'I can't let you go back.'

While mental health and addictions workers did not immediately become trauma experts, they did become much more comfortable hearing disclosures:

When they are telling the story, their experiences, we get better at understanding what they need.

The Benefits of Screening for Woman Abuse

Despite their initial fears and the worries about how to follow-up after a disclosure of abuse, and their concerns about wait lists, front line workers quickly began to see why asking is important:

Yes, there are wait lists, but the woman knows that there is a person to speak to. You are really helping with safety issues and crisis issues.

Back to why it is important for the counsellors to know, for those working in Mental Health when a woman is experiencing some symptoms, now the first response isn't to rush them to a psychiatrist; it's to explore the question further. You do some safety planning.

I had one client who had been in the mental health system for about twenty years and who had experienced abuse for most of her life but never talked about it. Her current abuser was someone who she had met in a mental health program and she was not being supported at the program. She was the one who had to leave the program to get away from the man who was harassing her.

Workers became more familiar with the network of community resources to help women experiencing woman abuse and abuse-related trauma:

For us the trauma program has really been helpful. Past that, there is only group and some private counselling. The shelters are good for current abuse. But the trauma program has been helpful taking women into one year and sixteen week programs.

Some benefits of implementing screening reflect opportunities for personal or organizational learning, growth and development:

We can make the referrals and become more aware of the services.

We're able to assess it [trauma] more. The language is there, the comfort zone, the screening is there. We're talking about it and the clients are talking about it and we are trying to make changes

I think it's led me to take it [our relationship] from a professional level into her everyday life. Before we began screening my first response would have been, it's depression or anxiety. Now I ask, 'How is home?' I'm more comfortable talking about [abuse] in general conversation.

I don't think I understood some of the warning signs, symptoms, triggers. In the past, sometimes I had no idea about the trauma and I had been working with an individual for years.

It's knowing more about how to advocate.

Screening for woman abuse and abuse-related trauma, and learning about trauma has had a profound impact on the way behaviours are understood for some workers:

For me I've questioned the medical diagnosis and symptoms and tried to make more of a connection between how a woman is behaving and what has happened to her. That's how I have grown most and how we as an agency have grown the most.

We are dropping the all-encompassing label of personality disorder. I think that's one of the most important benefits for me. Let's step back and look at this behaviour.

I ignored the language of personality disorder.

Lucky for you [that you could ignore that language.]

Front line workers discussed the many ways screening helps to provide better service for women. The first benefit is knowing that a woman has experienced abuse so that the problem can be addressed:

It gives people an opportunity to talk about something that has happened in the past and they can come forward and seek help and get help.

Screening is bringing an important issue to the surface so that we are thinking about it and acting on it.

The most important thing is that one client that responds for the first time and gets the help she needs.

Once workers know that a woman has experienced abuse, it helps them to plan for and provide more appropriate service:

I suppose for mental health counsellors and advocates, knowing it's about abuse helps us to develop a plan of action for the client or a treatment plan.

In treatment programs, it gives us a better idea of where to place women. We don't want to put someone who is vulnerable with someone with a history of abuse. We look for signs and symptoms of re-traumatization. We work through a conversation and identify the issues if she is going through a crisis.

I think too it's helpful for the case management, to help identify triggers that could send someone into crisis when we are trying to figure out a rehab plan.

I mean part of what this is talking about is addictions and it helps us to understand why a person is using substances. For counselling and treatment, it tells us what kinds of support we can offer.

The women are going to respond better to the rehab process because you've nailed the source of the problem. You're surfacing complexity.

It's also important in a residential program. We would make consideration for a female coming in, staffing considerations. We would assign them a female worker and offer gender specific programs. Not everything is exclusively mental health or addictions or trauma. Sometimes it is blended; sometimes women need a chance to step back from men who have been their abusers.

I've been in situations where women wouldn't have been able to get in the shelter on her own. She didn't have the capacity to answer the questions on her own. Workers really go to bat for her.

I think another impact on my community support work is that I'm really aware of how to work with people now. Out of hearing stories, it has helped me understand

why this person can't get into a car, or why she panicked when I took a different route. She panicked and thought that I was taking her someplace else. We stopped for gas and she said, I don't know where I am. It really has helped me to always be aware of how much the trauma and abuse still affects the individual and to understand how in a trusting and therapeutic relationship she can still have these feelings.

As a mental health support worker you're not just focused on the symptoms. You're focused on the trauma, on the addictions. They aren't with the community support program as long. They aren't just relying on mental health work when that isn't the basis. You have a sense that there is change and for me that's core.

Once they began screening and learning about a woman's history of abuse, workers also questioned some of their own past practices:

In the mental health world, we try to bring the family in, sometimes not knowing the father [or another family member] is the abuser. Your suggestions will be more valuable to the client when you understand the abuse.

The number of times in the mental health sector we have referred women to another service, but without knowing that piece [the abuse], without having a really good understanding of it, without exploring if, we are not sending them into a healing place, but a place that can bring out much more fear and discomfort and mistrust. Also women are being abused by the men who they meet in those programs.

In particular, workers questioned a course of treatment that offered only medication:

And from my perspective if a woman has a diagnosis that is valid, medication alone is not enough for her to recover. It has to be more than that. You can't have a good response or a good treatment response if you don't consider her history.

Many women just get medicated. There are certainly a lot of women who come to us who appear to have a valid diagnosis; we're not doing that assessment piece. But that's all they are getting, medication and going to the psychiatrist. They don't get any support other than that. You need something beyond the medication to move, to see any kind of movement. The medication isn't enough. It just dampens some of those symptoms, or helps manage them.

A counsellor from the violence against women sector summarized the importance of mutual learning for the benefit of clients:

I think abused women need the people they go to in these fields to be trauma informed and for those of us in the trauma business to be informed about mental health and addictions issues. Otherwise, I don't think we provide them adequate, responsible service. If you don't ask a woman about her trauma history and you

don't take this into account with whatever service you are offering, you are not offering her the best possible service.

Changing Relationships with Clients

Workers found that understanding that a woman's mental health and/or addiction problems are rooted in a history of abuse changed the nature of their relationships with women:

There is more trust between client and supporter. The women that we work with know that we know the whole picture. There is nothing hidden in that relationship and it builds a lot more trust. It changes what's done with the woman and how it's done.

I think it's got to deepen the relationship and create more relational opportunities because the women can bring all of herself to the relationship.

Promoting Healing

Front-line workers agreed that knowing about the abuse a woman has experienced and understanding the effects of related trauma, promotes healing for the women they work with:

It's a more respectful and a more healing way of doing the work. If she can be more fully present in all of who she is and all of what she's doing, it will be more impactful for her.

It validates her experience, when other people know about it. It helps her to understand better how it has impacted the rest of her life.

Being listened to and heard is validating, but it is also healing. It's healing to tell that to someone in a safe environment and to be heard and be believed.

It can make a huge difference to those women to have it normalized. It's not 'you're crazy mentally ill,' it's 'look at what you've been through.' It's a completely normal reaction to be depressed and to have black outs. Those pieces are not about mental illness. It's a normal human response. And I've seen it totally alter how someone sees themselves, to believe that theirs is a normal response, not, 'I'm bi-polar.'

Some of the women feel more valued that someone is taking the time to ask. And if you have the luxury of working with that person for a time, you understand why they are acting as they do.

Some workers saw that once women were able to disclose and were believed, they were able to act to protect themselves:

I think it's almost given them permission to say that they don't have to put up with it.

Challenges

Front line workers remained committed to screening for woman abuse, but they did acknowledge and discuss a range of challenges that arose for them. As discussed above, knowing about abuse is important for the immediate safety of a client, but wait lists for more follow-up service remain a challenge:

It's in our nature to want to help women and sometimes we can't facilitate it because of the barriers. The wait lists, they present new challenges.

Coming from the assessment perspective, in my agency we have a two-month wait list. They leave the office and I hope they will be okay. Is there something more I can be doing?

Workload issues also remained a challenge for some:

And our time, we have how many other clients and based on our assessment schedule. It is difficult to do everything.

Workers found it difficult to witness the destructive impact of women returning to an abuser:

Once someone discloses and they go back, it's really hard for me not be judgmental, to be patient. You have to just be willing to ride out the storm. It's back and forth.

Sometimes women are still with the abuser when the front-line workers meet them. Although the signs of abuse may be there, the woman may not be able to disclose directly:

I had a recent situation with the husband being there. I don't think she had a choice to say no to him. There would have been repercussions later when she was at home. The work is dictated by protocols, but I have to balance that against how much risk I could be putting this individual in.

I've become aware of that. I had to read the signs. This man was challenging to me – what must she go through? I worry about that. What kind of position am I putting this woman in? We agreed our rehab plan would be just to have coffee with her. Who am I to say you need to go out more if that's going to cause trouble in the home.

We are a threat to the abuser and that's a challenge.

While removing an abuser from a woman's life may create safety and more space for healing, it can also leave the woman feeling isolated and alone, at least in the beginning:

I've had circumstances where the abuser ends up being charged. The police are involved and Victim Witness and it's probably been a year and four months and that's the only person she had real relationship with and now that there's charges and restraining orders and you're left with saying, 'okay lets go find a friend.'

Screening for woman abuse created general awareness of the issue for front-line mental health and addictions workers and added a new complication for their work:

I just wonder too, on our caseloads if we are sometimes supporting the abuser. With our new compassion and understanding, how difficult does that make your job? He's bipolar, okay, but then you have a new understanding of the women he is abusing.

Women who are still living with (an) abusive family member(s) or who maintained contact with (an) abusive family member(s) posed a particular set of challenges:

When the abuse has been in the family and when the family has come back to staff and denied it, there's that awkwardness. We have to work with that. We have to engage on a very subtle level. We haven't had a lot of training on how to engage the family without increasing the abuse.

Sometimes after the home visits, they will come back a mess. There is a repeat pattern. After developing safety plans, there is frustration; but it's riding out the storm. You're pulling out everything you have skill-wise to remain calm, but it's back to square one.

Workers found situations involving children presented particular difficulties:

That's another whole issue when you see people with their children. The children are carrying all of these stories. The ex-husband said he was going to strangle her.

For us it goes even further when an individual reports abuse and there are children involved. It's gone as far as going into legal issues. It can be just very complicated.

Sometimes there is a trust factor. She's had CAS involvement and there's her reason for not trusting. She's smart. I tell women what I need to report from the start.

Having sufficient resources to implement woman abuse screening, and then follow-up with appropriate support, was sometimes challenging:

There has been some internal strife; some splits between internal value systems. Some have asked, 'why are we spending money on that?'

We need more resources and training, the bottom line is sometimes there's not the resources to do it.

Women may not be as willing to disclose to a male worker as to a female one:

In treatment programs, we have a lot of male workers. When they ask the question, they get a pause. People don't always divulge the first time. Sometimes they will later.

The team can be a barrier. The male staff asking the questions can be a challenge.

Vicarious Trauma

It is inevitable that front-line workers will be affected by the stories of abuse that they hear. The initial shock and surprise of hearing so many stories was particularly difficult:

I think initially, when we first started asking and we were asking the questions and hearing the stories and these people we thought we knew so well were disclosing, people were really feeling the vicarious trauma. We really had to take a step back and think about when we ask those questions.

Some workers felt inundated with accounts of abuse:

In assessment, I'm struggling, having to hear those stories every day.

It is a challenge on another level because you are not seeing those women day to day. When they leave the office, you don't know what happens to them.

Workers too, may have a history of abuse and they can be triggered:

It could bring up experience in our personal lives. The woman abuse training did that.

Front-line workers also felt the impact of the need to interrupt or modify services for their own safety:

We feel guilty if we have to remove the person from the program because of staff safety. They have to start all over again with someone else. That comes back to vicarious trauma and having that support in the staff group.

Some workers did feel that once the initial shock at hearing stories of abuse was over, it became easier:

I wouldn't say recently staff have expressed concern about having to hear the stories and how traumatic that is.

It is not possible to avoid vicarious trauma when you are working with women who have experienced a great deal of abuse. The challenge then becomes to create a culture that acknowledges vicarious trauma as part of the job and that ensures adequate supports are offered:

The vicarious trauma is a challenge and staff recognizing that and feeling that they are not being judged for it.

Organizational Change

The agencies that participated in the project to implement a woman abuse screening were changed by the work. In the mental health and addictions sectors, the importance of understanding trauma began to be reflected in hiring practices, in the focus of training and in the way work is conducted on a day to day basis:

The agency has incorporated trauma into their hiring.

Now we hire differently. We hire people that have backgrounds in trauma, we look at that. The staff that are there now are trained in a different way. It's just an accepted part now.

We have a new computer system; we're talking about how we can put the woman abuse form on that. We're also taking about making it more generic, we have had discussions about how to make it more generic for everyone. I think in our day-to-day work, that's a very concrete change, our protocols, our trainings.

The violence against women sector has also been changed by working more closely with mental health and addictions agencies. A shelter worker explained:

I'll tell you how it's affecting us. We are getting a lot more referrals and we have two mental health workers on site. We are getting a lot more cross training and we are more comfortable and staff are much less likely to say we can't deal with these women. The women we are working with are getting better service. It takes a phone call and those women are connected to services. That's with mental health issues. With addictions, we wish we had addictions workers at the shelter too. That's something we are catching up on. We went from we can't deal with any kind of substance to be a little more open about it. The woman are being serviced better and staff are more comfortable. We knew as soon as the screening protocol started this would start.

Safety for Front Line Workers

Although the project was focused on providing safety for women, mental health and addictions agencies also learned to consider the safety of workers in a new way:

I think the safety piece has been overlooked in the mental health and addictions fields and its not just the woman and the children, it's the worker. You may put the worker at risk if she goes into the home and there is an abusive partner. And you may also put her at more risk. So I think the safety piece has been missed unknowingly.

Safety is important. If someone comes in who has an abusive partner, now we ask, 'Can we safely house her? We ask before placing her; 'will she be at risk, or will staff?'

That's the same as us in community support group programs. We ask 'Can staff safely visit?'

There are times when we enter client's homes to work one on one. Now when they have abuse issues, you get another staff to come with you if you aren't comfortable.

I think in terms of safety, with Community Support Workers, we contact someone when we feel the situation could become dangerous if there has been abuse in the past or if it is still ongoing.

Safety from Workplace Harassment

The issue of workplace harassment and the threats to the safety of other workers such behaviour poses also surfaced during the project:

I was thinking about the Project Coordinator's experience when she went in to support the staff about woman abuse and she became the safe person to talk to about a manager who was abusing the workers.

As the project opened dialogue within the agency about the importance of safety, the manager's co-workers disclosed how his behaviour made them feel:

His behaviour at work was bullying, very, very bulling. There were women too who he supervised that were afraid of him. He made comments in meetings. The women were terrified to speak in meetings, but this all came out, one by one, by one.

Participants in a training organized by the project also witnessed his behaviour:

He also outed himself as an abuser at a trainer.

He was talking about tactics of abuse, the [power and control] wheel, and he said, 'well that can't be, that happens in my house all the time.' Kinda like, 'that's really effective.'

Initially, the workplace failed to recognize how problematic this behaviour was:

But he had so much charm going for him. We had his manager calling and saying I know he's a bit rough around the edges, but just overlook that.

Eventually the agency did understand that this worker's abusive behaviour was very problematic and they took decisive action. Participants in the project linked this willingness to address internal workplace harassment to the successful implementation of the woman abuse screening protocol:

That agency took responsibility for making a change. To get rid of a staff person is huge. The courage it takes to do something like that is huge. I think it's good because it's now known that that behaviour won't be tolerated. Maybe that's why the organization has taken it [the screening protocol] up so strongly. It's the culture. If abusers are tolerated in the workplace, they will throw up barriers to doing this.

It was a very difficult passage. It was a make or break thing on whether or not the screening protocol was going to be taken up by the agency. It was a culture shift.

Working Differently – Increasing Collaboration

There was resounding consensus that as a result of this project to implement woman abuse screening, agencies in the three sectors of mental health, addictions and woman abuse are working more collaboratively. The changes have come about as a result of relationships and are sustained by relationships. These relationships are benefiting workers and clients:

Yes, developing rich relationships across the sectors made a big difference. Even relationships on the project committee have made a big difference. We have workers everywhere now. It's so much less isolating, I feel so much less alone. We are less fragmented and less alone. We've come out of our corners.

I think we are all doing our work differently now. That's an interesting outcome. I know we are all stretching and bending more to connect with women with mental health issues. It's been a good move, but there's been some friction as we've tried to make changes.

It has completely changed how we do our work in this community, it completely changed everything.

The work is shared.

It changes everything, it changes the way you work with somebody; it changes where you would support that person in getting further assistance.

The benefits of sharing the work have continued past the initial stages of training and implementation:

I was thinking about that training piece and about how agencies have started coming together and bringing in speakers and inviting other agencies to join them. Having [multiple] agencies who have agreed to this is helpful to a woman who goes between agencies. Instead of having to go back to the beginning each time, each agency has a shared understanding of what she is dealing with. We now have a partnership with [the woman abuse counselling agency], that's really good, an important benefit.

I think sometimes we do get around the table and we get to see each other's faces and we see that we care and we're invested. We are not just dumping our clients.

In assessment before, we took the symptoms as symptoms and now we look at it differently. We ask, 'what services do they need?'

We're speaking the same language now. I don't feel as if I'm pounding my head against the wall and they [women's shelters] understand more about mental health. They had all these rules, clean and sober before they would take our clients. There are a few less barriers. They aren't all taken down.

A new model for working with women across the three sectors has emerged:

We are articulating a new model, its something about an integrated comprehensive continuum of support. It seems to me that is what we've created here. It's a new old model of working with women, with wherever they are at. We're not there, but we have glimpses of what we want.

An integrated model doesn't put the onus on the woman to find the right service. Helping women to get to the next door shouldn't be her responsibility.

Front-line workers noted that their influence had spread beyond the agencies that participated in the project:

I think some of this change in attitude has spilled out into the larger community, to the police and crisis services. Police officers are more responsive in a positive way to women who have been in abusive situation and have mental health issues. If we could just get the hospitals on board.

A significant outcome of the project is the increased capacity of workers from the three sectors to serve marginalized women:

We've really asked the women about their histories and what they want. I think it's a very woman-centred relational piece, not assuming that we know. We are starting from a place of not knowing. It led us to working more with homeless

women and sex workers, with those women that we don't always know the answers for. We are seeing more women in the sex trade. Not having all the answers, but walking with them. We are working more and more with marginalized women, who fell through the cracks before.

Creating New Services

One of the most notable outcomes of the collaboration is the creation of new services and new ways of delivering services.

My Sister's Place was established through the collaboration of mental health, addiction and woman abuse agencies. It provides safe day space for women who are homeless or at risk of homelessness, making available supports, programs and basic needs such as a daily hot meal, clothing, laundry, showers and hygienic products.

A worker states the importance of providing this service:

Without My Sisters' Place, there would be women who would be dead, quietly dead. We are working more with women who our society has marginalized.

At the time of publication of this manual, My Sister's Place is still without secure core funding. It survives through the ongoing commitment and efforts of workers from the mental health, addictions and violence against women sectors to do whatever it takes to keep the doors open.

The Tripod project complements the screening protocol project. Tripod is specifically designed for women who have experienced, or are experiencing, woman abuse and abuse-related trauma as well as mental health issues, substance use/dependency or a concurrent disorder (mental health and substance use). Participants must be sixteen years or older. There is an intake meeting with the woman to determine if she is suitable for the program. This program offers one-on-one counselling and psycho-educational groups that include topics such as safety planning and healthy relationships. It is a three-year project, expected to end Feb 2008.

A worker commented on the importance of this project saying:

How many women have realized something different in their lives and been able to move forward because someone asked them the questions?

Another important development in services for women is the provision of women-only residential services in the mental health sector. A member of the project committee commented:

I remember when we sat around the table, about five years ago and there wasn't women's only housing. And talking about the need for that and now it's become a reality. The mental health agencies have really taken this up and understood the

piece about trauma and they have really transformed the services because this is what some women really need. They don't feel safe in co-ed services.

A mental health sector work explained further:

There have been changes in the housing program. We have three residences for women only now. Two are unstaffed and one is staffed. That's all happened as a result of the screening protocol project.

One of the mental health agencies now has two outreach workers working in the women's shelter. Benefits have accrued to both agencies involved in this collaboration, and of course to women who find themselves in need of service:

There are two staff positions dedicated to violence against women shelters and they come back and provide information to us [here in the mental health sector].

[The mental health agency] has workers at the women's shelter. There are women who would have been asked to leave the shelter, but thanks to those workers, some women can stay and work on both pieces, trauma and mental health.

Lessons Learned

As those who were most closely involved in implementing a woman abuse screening protocol reflected on their process, they offered a few lessons learned that might be helpful for other communities heading into a similar process:

I think if I could tell an agency something, it would be, you are going to have that rough period, six months to a year before it really gels.

Before implementing the screening protocol one of the things we did was lots and lots of training; that is something I would encourage.

And agencies need annual training.

And partnerships; have the buy-in of management and staff. If staff are buying in because they see the need, that won't help unless management is on board. The three sectors have to work together with executive, management and the Ministry.

If there are lessons learned, one that we can pass on is to involve as many sectors as you can. Addictions and the medical sector too.

Its really good to have the woman abuse screening on the data base. I just recently read it and there was information I had sort of forgotten. We can review it from time to time.

For the purposes of other shelters from the violence against women sector that might want to institute a screening protocol, I know that as we started to get more

and more women particularly with severe mental health issues it was a real stretch for us. It's going to put some pressure on people to grow, but in the end that's going to mean better services.

It's the harm reduction piece that's important. Harm reduction doesn't sound safe to shelters that are serving women and families, but if we keep talking about it, we will learn. I wish we had addictions workers on site. It helps to integrate the knowledge.

One of the learnings for me is that the system is still geared for that [psychiatric] label. There is still a systems piece that is geared to that. Looking back, any woman that has trauma and is dealing with symptoms we have to look at that.

In those initial interviews sometimes, she will ask for another person to be present and the assumption is that's a safe person because the client has asked them to be there. But that's not always true.

I think agencies need to know that people will begin to identify if there is abuse going on in the work place and that it will be spoken about for the first time because there is a safe place to speak about it. It's not okay for our clients and it's not okay for us.

I'm wondering if we were doing this again if we wouldn't build in a piece for managers on what to do if you encounter abusers in your workplace. There is a way to respond to them and identify them and do something for them. When we developed the screening protocol, we were focusing more on the needs of women working in agencies who had trauma in their lives and the impact on them. We didn't appreciate there would be abusers in agencies.

Sustainability

Sustainability is a measure of success for any project. As members of the project committee reflected in this discussion, much more than just the woman abuse screening protocol will be sustained from this project. Participating agencies gained new ways of understanding how to work with women who have mental health and addictions problems and they created organizational structures to sustain these new understandings:

And our organization has taken it on. When you think about organizational change, this is a wonderful thing. When we started this project, we didn't know it would be taken up in this way. We were worried about having policies and practices so that's it's maintained over time and entrenched and that's happened. They have taken it on and internally transformed themselves and that's a great thing to see.

At our agency, we also have a very committed management group. And we have training about services that are available.

We do ongoing training about woman abuse. When new staff come in they sit down with a woman abuse trainer and they do reading.

Our women only service has amalgamated with a larger mental health service. I would have thought they would have been the last agency to embrace this. But this e-mail came across my desk, stating that we are updating our manual and we are making sure everyone is updated on their training with woman abuse and would trainers please contact so and so. And I thought, 'there are trainers?' It turns out that every department has their own trainer on woman abuse and they do this as a matter of course and I don't even know who these people are. It's a very nice switch. I think the work has been accepted more broadly across all sectors.

Other people are doing it and they aren't even part of our project. I understand that the violence against women service in a neighbouring county is doing a screening protocol project in conjunction with a mental health agency. It's nice to see it spreading on its own.

None of us should be the keepers of the knowledge. It should be an organic process of learning. I love that, I just love it. I think five years ago we had to prove what we were doing was valuable. Now that's recognized.

We had to do a little persuading.

Work Left to Do

The project to implement a woman abuse screening protocol was successful beyond the initial hopes of those who guided the work. The preceding pages have documented why. Yet there is still more to be done. Many women access services through hospitals that still do not make the connections between mental health, addictions and trauma:

That said I think that there is still some work to do with the hospitals. They are doing some great work with the PEPP program. First psychosis is in all likelihood a trauma response and yet they see it through their own lens. There are a lot of young women going through that program whose whole history is not being considered.

I do think bringing the medical sector in is important. They are moving at a glacial pace.

That's where you have to bring the hospitals in. It has to be done as collaboration. We've gotten better at collaboration, but we haven't integrated services.

We need to expand it to the hospitals and have the hospitals on board.

While agencies are working collaboratively to provide a better response to woman abuse and abuse-related trauma, they continue to be limited by funding restrictions that do not support long-term healing relationships:

We've identified it [trauma]. That's the educational piece. Instinctively we always knew it was about long-term relationships and all our work has turned into short-term funding. It's about building safe core relationships. Our counsellors will say I've done this piece and now you can do this piece. It's frustrating.

How do we move from being funded for six to eight sessions or six hours of work to be able to do something more sustained? I mean we stretch it out, but six hours is six hours. It's awful, but it's our reality.

Healing from trauma is a complex process, both for the woman and the supporter. This was acknowledged by front-line workers:

I think the next piece of work –we're asking the questions, we're identifying the women, but I don't think we have the approaches to deal with the complexity. It's all very good to identify that a woman has a trauma history, but she's not in a place of safety, stability for her to do that work. We're in a place where we're really good at doing grounding, but I'm talking about historical trauma.

We don't know how to respond because there is this ongoing cycle. I truly believe that trauma changes your brain chemistry. When you're hearing voices, when you're impoverished, it's difficult to work on trauma.

The new stuff is that you don't go into the trauma; you hold it while you work on the stabilization and grounding. You don't go into the trauma, you can re-traumatize. That's the problem. We can't do that work.

With characteristic resolve and commitment, members of the project committee looked forward to the next phase of this work:

We have to go back to our old community development models. I remember how we built capacities in our communities. Again, it's like going back with our new knowledge and putting it with what we used to do. There's a possibility.

So maybe we are at the beginning; the beginning of the middle.

The Women's Perspective

The final word about this project goes to a small group of women who are residents of a women-only residence supported by a mental health agency. They have generously shared their stories to allow for a better understanding how they and other women like them come to community services.

Some women saw themselves as experts on abuse:

When people ask me about woman abuse that's when my assertiveness comes out. People say, 'why don't women leave?' And that's where I jump all over them. Why do women stay, they're getting hit, they're getting whatever happens in the home, why, why? And I got that for many, many years. And now I'm at the point where I get angry. What do you mean why do women stay? I hate it when people ask that question. An outsider says, why do women stay, well there's about a hundred and fifty thousand reasons; security, kids' father, money, stability. I left and went to shelters and I went to counselling upon counselling and I went back. Why did I go back - because it's the only thing I knew. I didn't know anything different. I believe unless you've experienced or seen it, you yourself gone through it, I don't believe you have the right to ask questions like that. Like I say, I left a hundred times. I went back. I could tell you some horror stories, but I'm going to spare everybody that today. It's an ignorant question, why do women stay. There's many reasons.

Some had gone to great lengths to educate themselves, even before they connected with services:

I studied law for domestic violence and going to court for my kids. I studied law - studied law on my own, a good 10 years to understand what I've been through. I went right nuts with looking into anything and everything I could after I lost my children to know everything I could know. The judge was biased, right off the top, he was biased. I appealed it. They made their decision. I went to court and went to my trial and I appealed it thirty days later after the judge made her decision. I appealed it by myself. I got in my car and served everybody papers.

Others only learned to identify their experiences as abuse with the help of service providers:

I didn't even know I was being abused. He was my first boyfriend. I didn't know how I was supposed to be treated. Once I married him, he changed even more.

One of the most painful consequences of the abuse women suffered was losing their children:

He doesn't get the children. CAS took the children. Yeah because they figured my children were at potential risk because I was abused. I wasn't with him at my trial, because we were done, over, but they still found a way to use it against me.

I lost my children to the system. If you read my papers, I was all because of domestic violence.

Women recounted how their abusive partner controlled every detail of how they conducted their lives:

He told me what I could wear. I could only wear pink lipstick, not red lipstick. No gold earrings, I guess they looked cheap.

Before I got married, we moved in together. I couldn't wear a muscle shirt because all the bus drivers were looking down my shirt.

I thought it was because he loved me, he wanted me all to himself. He don't want me having friends. I wasn't allowed out of the house without the children, I wasn't allowed out of the house without him. I never walked down the street by myself. He wouldn't take both children at the same time. I always had to be babysitting.

In grade eleven, I had an engagement ring, five diamonds. I was his then.

And he turned the heat off at night.

If I was humming, he'd get mad.

Oh yeah, my husband he hated me smiling.

If I sing along with a song on the radio, fine. If I sing a song by myself acapello, he'd get pissed off.

Women spoke of how their abusive partners used the children to control them:

My husband, the two kids we had, those are his kids and he kidnapped them I don't know how many times, just so that I would chase him. Oh yeah we'd be walking down the street and I'd try to run for the pay phone and he's got the baby in the buggy. He leaves her there and I'd go running and try to grab her. He grabs her before I get across the street and toys with me and eventually walks.

In the middle of the night the baby was screaming. I usually made 8 bottles, I made 7. The kid was screaming. My husband yells from the bed, shut that kid the f-ing up. I had to leave my baby screaming in the crib [to make another bottle].

I went through the same thing you did and it creates ten times more stress on us. It creates so much panic. I went through the same thing you did.

The women also detailed their experiences of physical, sexual, emotional and financial abuse:

I had black eyes all through high school. I constantly wore sunglasses.

I wrote down how we had sex at [the counselling agency] and they had to inform me it was sexual abuse. He thinks sex is dirty, like his mother does.

I was on disability and he wasn't working. I paid for everything.

He pawned our wedding ring.

He took all my money.

So did mine

I can't take the bus any more if I don't have any money. He made sure we lived way far away.

It goes like this. We get in the car and he says go cash your cheque. I go and cash the cheque and I have \$700. I bring it in the car and I sit down and he goes give it to me.

These kind of men, if you don't give it, they take it. At any and all extreme. If I had it and he wanted it. I said just take it. But when he started taking from the kids that was different.

The women also recounted childhood abuse:

My stepfather tried to strangle me and he also punched me in the head.

My mother too and my father too. She used a wooden spoon on me because I peed the bed and made more work for her. One minute she likes me and the next minute she didn't.

Is telling your child - my stepfather and my mother telling me I can't be friends with black people - is that abuse? My mother's against poor people and my stepfather is against black people. My parents are rich. I brought a friend home and asked if we could swim in the pool. My mother said yes and we were in the pool. My father came home and yelled get that 'f-ing nigger' out of the pool. She ran then and I never saw her again after that. Is racism abuse?

The women clearly related to each other's stories and in conversation with one another, deepened their understanding of the dynamics of woman abuse:

Yours was worse than mine. I didn't get black eyes all the time. It was a lot of verbal.

I was grateful I got hit. But to this day I'll say to anyone, anywhere, I would have rather taken twenty-five shots to the head than the emotional and verbal abuse. Black eyes go away, the other stuff stays. Give me a shot in the head, I can handle that. That bruise will go away next week, but what he done to me, to this day has not gone away. I used to always say, just hit me. Cause he would get under my skin and torment me this way and there's no marks right?

Now I think it's easier to talk about it and now a days more people are paying attention, more people are getting a little smarter in that area today. I can relate to everything she said today. I think I married your husband's brother. Somebody understands. I find that it helps when I do talk about it.

The women recounted how a mental health diagnosis or even a threat of one was used against them to excerpt further control:

He said he was counting my pills. He had me in the corner and he was yelling at me. He puts his fist up and he was yelling at me. Then he slapped me hard and I used takwondo and that's how I ended up in London Psych – he made it seem like I did it for no reason. Like I was crazy and I just beat him up.

I told my mother [about my stepfather's abuse] and she said, 'we're going to put you away.' I wasn't even diagnosed with manic depression.

When I got diagnosed with manic depression he changed. He'd give me mean looks, the evil eye.

The women talked about their difficulty trusting anyone in the system. They feared that information they shared about their lives would be used against them, as it had been in the past:

I've lost all trust in the system. That [losing my children] killed all the trust issue for me. I'd like to be more open sometimes. The system and the women's shelter, the court system and the workers, they took me for a good ride. I guess I still got my guard up. I'm noticing, I still got my guard up. I really do.

They turned everything they could against me. That's one of my biggest issues. For a long time I couldn't talk to counsellors. For a long time, everything I said was used against me.

Last week I said I smoke pot. I smoke cigarettes and I smoke pot. That's the worst thing I do. But I was afraid to bring it up. Everything in my entire life has been used against me, like a noose around my neck.

The women clearly connected their past experiences of violence with their present circumstances:

Our self-esteem is so gone because of it.

I've been involved in domestic violence pretty much all my life. I've lived in many shelters from [one city to the next].

I endured domestic violence – for like ten years I was with this guy. I guess I'm where I am today because of domestic violence. Yeah I mean I have a lot to say when it comes to domestic violence.

The women were passionate about educating and reaching out to younger women, so that they would not have to experience what they had:

I firmly believe from what I have experienced in my lifetime, they need to go back to public school and start teaching these young kids right now what it's really like so they don't have to be like me and her. You actually get your foot out there in life and you're blindfolded. You think because he smacks you around, he loves you. No they need to do that and I believe they should start that in public school. Because my god, I wish I could go back and I wish they would've taught me. They need to start with some program that can help the kids to understand abuse. I wish to god they could have done that for me.

In a testament to the importance of the supportive connections these women had made and to their own strength, they remained hopeful that they could help others in the future:

I try to get involved. Once I'm a little better than I am now I'd like to be part of that somehow. I really would. I'd like to be part of helping women out who have been abused.

Another woman, who wasn't part of the focus group had this to say to the project coordinator:

I know that I was at [the addictions agency] for substance abuse problems, however my drug use was secondary to the current problem I was experiencing. The questions about woman abuse were asked even though I had come there to discuss my recovery goals. I had never made the connection between my current situation and my risk of relapse. No matter how I presented to J., he continued to prompt me and asked questions about my relationship. He knew how to respectfully ask me about my experiences with abuse and my current relationship.

Even though I presented as together, with a support system and the ability to articulate my experiences, he still asked. Nobody had done that before. This was a male worker acknowledging the abuse that I was experiencing as a mother/woman/survivor. It was significant coming from him because he was safe. I had spent only one hour with him and yet there was enough trust there that I did not feel judged for the relationship I was in and I could disclose what I needed to. I felt no pressure to follow through with the referral; his acknowledgement of the abuse was enough and I never felt that I was to blame for what I was experiencing.

The ironic thing is that it took me a year to even go to [the addictions agency], and I had to find out about it all on my own.

Appendix I

Tactics of abuse – “The Power and Control Wheel”

This is a visual tool that is useful in understanding how tactics are used by an abuser in order to maintain power and control over a woman.

Woman abuse in adult relationships is generally defined as: The intentional and systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a woman. The tactics can include, but are not limited to, the examples below.



Originally developed by
The Domestic Abuse Intervention Project, Duluth, USA

Further adapted by: The London Abused Women=s Centre

Appendix II

The Woman Abuse Screening Protocol Baseline Survey for Participating Agencies

The purpose of this survey is to assess current practice in screening for woman abuse in your agency. The answers you give will provide a baseline from which we can measure the impact of the training and implementation of the Woman Abuse Screening protocol.

We thank you for your participation in this important pilot project.

Date: _____ Your Code: _____ Agency Code: _____

Please describe your position in your agency:

1. **Do you currently ever ask women clients if they ever experienced abuse?**

1 yes 2 no If your answer is 'yes' please continue, if your answer is 'no', please go to question 1h)

a) Do you ask about abuse *only* if you suspect it or if the client has revealed it to you first? 1 yes 2 no, I always ask

b) Are questions about abuse *routine* in your agency's Intake/assessment? 1 yes 2 no

c) Would you ask a client regardless of her age or at approximately what age would you begin to ask? 1 any age or age:

d) Do you ask about physical abuse? 1 yes 2 no

e) Do you ask about sexual abuse? 1 yes 2 no

f) Do you ask about emotional abuse? 1 yes 2 no

g) When would you normally ask a client about abuse?

Everyone should answer the rest of the survey.

h) If you encounter a client who has experienced abuse, do you routinely document her history of abuse in her case notes or in the intake/assessment?

1 yes 2 no If you answered 'no', what do you do with the information?

- i) Does your agency have a written policy/protocol for dealing with disclosure of abuse in clients age 16 and over? 1 yes 2 no 3 don't know
- j) Considering the clients you have contact with currently, please estimate the percentage who have disclosed abuse. _____% 1 don't know
- k) In the past, has your agency provided an opportunity to attend training about abuse in clients age 16 and over? 1 yes 2 no 3 don't know
- l) If you encounter a client who has experienced abuse, do you (check all that apply):
- 1 refer her to an agency that specializes in abuse issues
 - 2 refer her to someone else in your agency that specializes in abuse issues
 - 3 deal with the issue yourself
 - 4 other: _____

m) If you refer out, to which agencies or individuals do you typically refer?

- n) If you encounter a client with current abuse issues, do you discuss safety planning with her?
- 1 yes 2 no 3 sometimes

- o) How knowledgeable are you about local resources for clients who have experienced abuse? (Please circle one number).

Not at all knowledgeable	Very knowledgeable
1	5
2	4
3	3

- p) How knowledgeable are you about woman abuse in general? (Please circle one number).

Not at all knowledgeable	Very knowledgeable
1	5
2	4
3	3

- q) How comfortable do you feel discussing abuse issues with your clients? (Please circle one number).

Not at all comfortable	Very comfortable
---------------------------	---------------------

1

2

3

4

5

- r) How difficult do you feel it will be to introduce routine screening and documentation for woman abuse into your agency? (Please circle one number).

Very difficult

Very easy

1

2

3

4

5

- s) What barriers do you foresee in your agency to introducing routine screening and documentation for woman abuse? What suggestions do you have for overcoming these barriers?

- t) What information/topics/skills would be useful to you at the upcoming training?

- u) Please make any comments or suggestions you wish about the project.

Thank you for completing the questionnaire.

Appendix III

Woman Abuse Screening Project Baseline Survey for Participating Agencies Final Summary November 2003

Survey questions:

2. Do you currently ever ask women clients if they ever experienced abuse?

1 yes 92 (80%)

g) Do you ask about abuse *only* if you suspect it or if the client has revealed it to you first?

1 yes 63 (65%)

2 no, I always ask 22 (35%)

h) Are questions about abuse *routine* in your agency's Intake/ assessment?

1 yes 47 (49%)

2 no 48 (51%)

i) Would you ask a client regardless of her age or at approximately what age would you begin to ask?

1 any age 87 (94%)

or age: 8, 12, 16

j) Do you ask about physical abuse?

1 yes 91 (96%)

2 no 4 (4%)

k) Do you ask about sexual abuse?

1 yes 88 (93%)

2 no 7 (7%)

l) Do you ask about emotional abuse?

1 yes 90 (95%)

2 no 5 (5%)

g) When would you normally ask a client about abuse? (Check all that apply.)

1 intake 34

2 assessment 46

- 3 counselling session 37
- 4 case management 35
- 5 any time it comes up 62
- 6 other: _____

Everyone should answer the rest of the survey.

h) If you encounter a client who has experienced abuse, do you routinely document her history of abuse in her case notes or in the intake/ assessment?

- 1 yes 97 (84%)
 - 2 no 17 (15%)
- If you answered 'no', what do you do with the information?

m) Does your agency have a policy/protocol for dealing with disclosure of abuse in clients over 16?

- 1 yes 29 (25%)
- 2 no 35 (30%)
- 3 don't know 48 (42%)

n) Considering the clients you have contact with currently, please estimate the percentage who have disclosed abuse.

Range 2 - 100% (average=56%)

- 1 don't know 45 (39%)

o) In the past, has your agency provided an opportunity to attend training about abuse in clients over 16?

- 1 yes 46 (40%)
- 2 no 34 (30%)
- 3 don't know 33 (29%)

p) If you encounter a client who has experienced abuse, do you (check all that apply):

- 1 refer her to an agency that specializes in abuse issues 100
- 2 refer her to someone else in your agency that specializes in abuse issues 28
- 3 deal with the issue yourself 53
- 4 other: _____ (see open-ended answers) _____

p) **If you refer out, to which agencies or individuals do you typically refer?**

_____ (see open-ended answers) _____

q) **If you encounter a client with current abuse issues, do you discuss a safety planning with her?**

- 1 yes 91 (79%)
- 2 no 6 (5%)
- 3 sometimes 17 (15%)

r) **How knowledgeable are you about local resources for clients who have experienced abuse? (Please circle one number).** *Average=3.57*

Not at all knowledgeable					Very knowledgeable
1	2	3	4	5	
(1)	(14)	(38)	(41)	(20)	

u) **How knowledgeable are you about woman abuse in general? (Please circle one number).** *Average=3.70*

Not at all knowledgeable					Very knowledgeable
1	2	3	4	5	
(2)	(8)	(30)	(46)	(18)	

v) **How comfortable do you feel discussing abuse issues with your clients? (Please circle one number).** *Average=4.06*

Not at all comfortable					Very comfortable
1	2	3	4	5	
(1)	(6)	(17)	(51)	(39)	

w) **How difficult do you feel it will be to introduce routine screening and documentation for woman abuse into your agency? (Please circle one number).** *Average=3.71*

Very difficult					Very easy
1	2	3	4	5	
(2)	(10)	(30)	(47)	(23)	

Appendix IV

The Woman Abuse Screening Protocol Project Presents:

Helping Professionals Make the Connections: Violence Against Women, Mental Health and Addiction

Routine screening of women age 16 and over who have experienced or are currently experiencing abuse

Key Learning Objectives:

- ❖ Understand the importance of screening for abuse issues, more specifically for abuse that is experienced in our society by women and girls
- ❖ Identify unique concerns of women clients who identify as survivors of abuse with substance abuse problems and/or mental health problems
- ❖ Develop enhanced sensitivity towards women who have experienced trauma or women who are currently in abusive relationship(s) and also experience mental health/addiction problems
- ❖ Apply the Routine Universal Comprehensive Screening (RUCS) Protocol through role plays
- ❖ Network, dialogue and share ideas with other social service providers who work in a similar capacity as you do either in the Anti-violence, Mental Health or Addiction Sector(s).

Workshop Agenda

TIME	ACTIVITY
8:30 – 9:00	Registration, Refreshments and Display Tables with VAW Resources
9:00 - 9:30	Welcome and Introductions-
9:30 – 10:30	Woman Abuse Awareness
10:30 – 10:45	Break
10:45 – 11:45	Sexual Abuse
11:45 – 12:00	Question Period
12:00 – 1:00	Lunch (Provided)
1:00 – 1:45	Implementing Woman Abuse Screening
1:45 – 2:45	Case Scenarios in small groups (specifically addressing clients presenting with diverse needs: rural, Aboriginal, and war-trauma)
2:45 – 3:00	Break
3:00- 4:00	Helping Professionals Taking Care of Themselves and One Another-
4:00- 4:30	Wrap up and Evaluation

Appendix V



The Woman Abuse Screening Protocol Project Workshops
**Creating Safety for Women: Mental Health and Addiction Service
Provider's Response To Abuse Disclosure**

AGENDA

0845 – 0900	Registration and Refreshments
0900 – 0930	Welcome and Introduction of Participants
0930 – 1030	Creating Safety for Women Who Disclose Abuse: A Standardized Safety Plan in Community Mental Health and Addiction Settings
1030 – 1045	Break
1045 – 1200	Creating Safety Within Our Agencies for Abuse Disclosure <i>Woman Abuse Agency Trainers will facilitate the following case scenarios in discussion groups (incorporate the safety plan for each group):</i> Participants select the group they would like to participate in A- Safety planning in a residential setting B- Crisis, intake and info./referral services: When and how is it appropriate to ask the questions regarding abuse? C- Indicators of abuse and identifying triggers for clients and staff
1200 – 0100	Lunch
0100 – 0230	Creating and Maintaining Safety for Clients Who Disclose Abuse
0230 - 0245	Break
0245 – 0400	Creating Safety Within Your Staff Team: How to Debrief After Abuse Disclosures Within The Structure of Your Organization <i>Group work exercise facilitated by the Woman Abuse Trainers</i>
0400- 0415	Workshop Evaluation

Appendix VI

Interview Guide for Managers

- Are you still doing woman abuse screening? Have you made any modifications? If so, why?
- Has woman Abuse Screening been effective?

Training

- What training has been offered to staff?
- Which staff have received the training?
- Was it one time training or is it ongoing?
- Do you budget for an annual training ?
- What are your staff training costs?
- Do you need more training?
- Are the tools we developed helpful? (screening protocol, safety plan)

Policies

- Have policies and procedures changed as a result of implementing woman abuse screening?
- Have job descriptions changed as a result of implementing woman abuse screening?
- Have hiring practices changed as a result of implementing woman abuse screening?
- Are new employees aware of woman abuse screening?

Staffing

- Have you had staff to support the implementation of woman abuse screening?
- If so, how important was that?
- Do you continue to have a designated person in your agency to ensure screening is taking place, materials are up to date and staff is trained? How do you foresee sustaining that? What are the barriers to doing that?
- Have your internal communications changed as a result of implementing woman abuse screening? If so, how?
- What has been the impact of asking questions on the staff? Have staff reported or have you noticed they are experiencing more vicarious trauma?
- Do staff routinely engage in peer consultation and peer support?

Data Collection

- Is data being collected on screening?
- If so, who collects it?
- Is data being summarized and analyzed?
- Is it used for planning?
- Were there administrative challenges to implementing a data collection system?

Management

- What would have been helpful to know that you didn't know before you started implementation?
- What are the barriers to implementing SPAW? Do you have ideas for addressing these barriers?
- Have you changed your supervision practices? If so, how?
- What kind of training has been provided to supervisors to implement SPAW?

Board of Directors

- Has your board of directors been informed about woman abuse screening?
- Would an information package on woman abuse screening for board members be helpful?

Clients

- Have you noticed that SPAW has had an impact on the service that clients receive?

Systemic Issues

- How has implementing woman abuse screening changed relationships with the VAW sector? Is there more interaction? Support? Collaboration?
- Have you maintained connections with contacts in the VAW sector?
- Can you rate how strongly you would endorse other agencies in your sector implement woman abuse screening across the province? Using a scale of 1 to 5 with 5 being very strongly endorse.

Focus Group Questions for Service Providers

Did you understand the connections between woman abuse, mental health problems and addictions before the SPAW training?

Why is it important for Addictions and Mental Health counselors and advocates to know if a woman has experienced abuse?

How did you know if a woman had experienced abuse before implementing SPAW?

What has been the impact on staff as they ask the question and hear the responses the questions about abuse?

Has your agency had to make any changes as a result of screening for woman abuse? What kind of changes?

Has implementing SPAW changed your relationships with other agencies? If so, how?

What has been the impact of asking about abuse on your clients?

What do you think has been the most important benefit of the SPAW training and protocol?

Have you experienced new challenges in your work as a result of SPAW?

What should an agency who is thinking about implementing SPAW know before they start?

Focus Group Questions for Women Accessing Services

1. Were you ever asked about woman abuse before your involvement with this organization?
2. How did you feel when you were asked about woman abuse?
3. Has talking about woman abuse made a difference in your life?
4. If it has, what kind of difference?
5. Do you think that all women aged 16 and over should be asked about woman abuse?

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Implementation of the screening protocol and much of the success of the project was facilitated by Mary-Jane Millar who was the Project Coordinator for the first two years, and by Nancy Wardrop of the Trauma Services, London Health Sciences Centre who coordinated the project during Ms. Millar's leave of absence, bringing her notable expertise on mental health and trauma.

Cindy Smythe of CAMH provided her expertise in evaluation and was a main supporter of the Project Coordinators.

The participating mental health and addiction agencies (listed on pages 9 - 10) are due the greatest of credit for taking on the often daunting task of having their staff and programs become trauma-informed and for committing to woman abuse and abuse-related trauma screening. The feedback from the managers and staff demonstrates that, while this undertaking was not without difficulties, the screening really made a positive difference in the services abused women received through the agencies and in how staff perceived the success of their support and interventions. For the openness to collaboration and innovation, these agencies and their management and staff are to be commended.

A small group of women shared their personal experiences and reflections about the connections between woman abuse related trauma, mental health and addictions. Special thanks are due to them for their courage and generosity to speak about their life journeys.

Barb MacQuarrie has researched and conducted focus groups to reconstruct how the project has unfolded for this manual. Megan Walker and Sandra-Lynn Coulter, London Abused Women's Centre, brought their sector's expertise to editing the manual.

WHMAARC and the Project Committee, on behalf of the writer and editors, encourage and offer support to other service providers who undertake woman abuse screening and to carry this worthwhile and highly successful work forward through collaborations with their local woman abuse and sexual assault experts.

