

**“[T]here has to be a better way to deal with this”:  
*Exploring the mental health needs of women residing in Violence Against Women  
shelters in Ottawa, Ontario***

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## **Executive Summary**

In 2016, violence against women (VAW) shelters in Ottawa reported an increase in the number of residents with mental health and substance use issues. Shelter managers approached Women's Mental Health at The Royal for help to meet this challenge. Although the violence experienced by VAW shelter residents is highly correlated with mental health issues, women residing in these shelters do not have equitable access to the psychiatric care offered at other homeless shelters in Ottawa.

With funding from WomensXChange , and in collaboration with Dr. Angel Foster at the University of Ottawa, as well as all six Ottawa VAW shelters, The Royal initiated a study to examine the mental health needs of this population. An advisory group with varying experiences of mental illness, gender based violence, and shelter use, assisted throughout.

We conducted thirty in depth resident interviews and six staff focus group discussions. Shelter residents completed standardized self-report mental health questionnaires. 63% reported mild to severe depression, 93% reported somatization, and 73% reported symptoms of PTSD. VAW shelter residents noted that, substance use, self doubt from gaslighting, isolation, motherhood and racism negatively impacted their mental health.

These difficulties created barriers for women accessing housing, navigating criminal or family court procedures, engaging with healthcare providers, and child protection services, as well as working and studying. For mothers, First Nations, Inuit and Metis women, and recent immigrant women, these barriers were greater, and more frequent.

What did shelter staff and residents think would make the situation better?

Overwhelmingly, participants in the study wanted more mental health services for the VAW shelter sector, including access to clinical intervention for residents, as well as mental health education and consultation for staff. Shelter residents also reported that peer-engagement with other women who had survived violence was therapeutic and valuable.

It is our hope that these findings can point decision makers and funders toward developing equitable access to psychiatric outreach services for women in Ottawa VAW shelters

## **Introduction**

The experiences of violence, which precede women accessing violence against women (VAW) shelters, are highly correlated with mental health issues for survivors (BCSTH 2011). At the same time, services to address gender-based violence, mental health, and addictions lack integration (Mason & Toner 2012). In the Canadian capital of Ottawa, Ontario, services to address these issues are separated by long standing philosophical and practical differences. For example, the Ottawa Alliance to End Homelessness (OATEH) comprises 55 member agencies, largely funded by the Ministry of Health and Long Term Care (MHLTC). OATEH studies trends in emergency shelter use and publishes an annual report card on homelessness. Missing from this report is data on women who access VAW emergency shelters funded by Ministry of Community and Social Services (MCSS). Historically, women who access VAW shelters were not identified as 'homeless'. These shelters are referred to as 'transition houses'. One outcome of not being identified as homeless has resulted in inequitable access to mental health services. MHLTC homeless shelters for women in Ottawa receive mental health services through Psychiatric Outreach Teams. No equivalent service is available to women accessing VAW shelters.

A significant practical difference between these two sets of shelters is their capacity to care for children. VAW shelters serve mothers and their dependent children; women's homeless shelters do not have this capacity or mandate. Having custody of children is a barrier for women seeking shelter. The role that mothers' mental health and substance use plays in women losing custody of their children is not fully known, in part due to the fact that the Children's Aid Society does not keep statistics specifically on mental health issues. Ottawa has one emergency family shelter mandated to house adults and their children. The majority of the adults with children in these shelters are mothers, sometimes also fleeing abuse. Failure to adequately address the mental health issues experienced by women in VAW shelters results in numerous deleterious impacts for them and their children, including losing custody of their children, increasing their vulnerability to experience more violence by leaving the shelter prematurely, and increasing their level of disability by not treating symptoms of mental illness. Currently, women with mental health and substance use issues are vulnerable to a downward trajectory after leaving VAW shelters.

Violence Against Women Shelters in Ottawa approached Women's Mental Health at The Royal for assistance in addressing the mental health needs of their residents. In collaboration with all six VAW shelters and Dr. Angel Foster and her team at the University of Ottawa and with funding from WomensXchange we undertook a study to examine the mental health needs and experiences of this diverse population of women.

We present our report in two sections: 1) An examination of individual characteristics and experiences of mental health issues of our study participants; 2) An examination of the intersection of mental health experiences and service provision systems. Additionally, we have included recommendations that will inform not only advocacy, but clinical education and assessment for both the VAW and the mental health sectors.

It is our hope that this information will be used to advocate for more equitable access to mental health services for women residing in VAW shelters.

### **Population & Methods**

Ottawa is located within the Champlain Local Health Integration Network (LHIN). With a total population of 1.3 million, 65% of the population lives in the City of Ottawa, 20% are francophone, 19% are immigrants, and 3.5% are First Nations, Inuit or Métis (FNIM). We know that in 2016 1,137 women (263 per 100,000) successfully reported incidents of intimate partner violence to police (Burczycka 2016). The LHIN does not keep statistics on women accessing VAW shelters. However, there are six VAW shelters in Ottawa with a total of 182 beds for women and their children; for 2016 they reported the following:

- Chrysalis House had 25 beds and served 80 women and 73 children;
- Harmony House provided 2<sup>nd</sup> stage housing and had 16 apartments;
- Interval House had 30 beds and housed 97 women and 167 children;
- Maison d’Amitié is the Francophone shelter with 30 beds and served 92 women and 96 children;
- Nelson House had a capacity of 15 beds and served 56 women and 55 children;
- Oshki Kizis is the FNIM shelter with 21 beds and served 97 women and 70 children.

In 2016, the VAW sector shelters housed 438 women and at least 461 children. These numbers exclude women who received other support through VAW crisis lines or from transition support workers operating out of these same organizations. It is also worth noting that these numbers are misrepresented by Statistics Canada which reports that 121 women (no data offered on children) used VAW shelter beds in 2016 (Statistics Canada 2016).

As can be seen by the gaps in data mentioned above, women who access VAW shelters in Ottawa constitute an under-researched population (Mason & Toner 2012). This study and its mixed-methods design is a contribution to the redress of this knowledge gap. We recruited 30 residents (approximately 5 women from each shelter) to participate in our study. VAW shelter staff invited members of the research team to ‘house meetings’ of all residents at each shelter, to discuss the project and invite residents to participate. We gave women in attendance a written consent form and arranged individual meeting times for individual in-depth interviews. There was an enthusiastic response to the research project and opportunities for involvement were on a first come first served basis.

Prior to interviews, we asked women to provide basic demographic information and complete three standardized self-report mental health assessments. Numerous studies have confirmed that the experiences of violence, and compounding systems pressures that preceded women accessing VAW shelters, are highly correlated with mental health issues, predominantly mood and anxiety disorders, including post-traumatic stress disorder (PTSD) (BCSTH, 2011). Therefore, we asked participants to complete the PHQ 9 designed to measure symptoms of mood disorders; the PHQ 15, designed to measure somatization; and the PCL C, designed to measure symptoms of PTSD. We used descriptive statistics, such as frequencies and cross-

tabulations, to analyze these results. Questions posed during interviews focused on women's experiences of mental health, the nature and quality of service interactions within the mental health sector, as well as suggestions for improvements to services and service integration (See Appendix A). By way of compensation, each participant received a 50\$ visa gift card.

To complement the in-depth interviews, researchers attended staff meetings to conduct one focus group discussion at each of the Ottawa VAW shelters; 63 staff attended. Questions focused on staff perceptions of the mental health of VAW shelter residents, staff experiences with these issues, challenges and successes in providing useful mental health interventions, and perception of need and suggestions for service improvement. We conducted In-depth interviews and focus group discussions in either English or French. Several participants identified neither language as a first language, though this did not hinder their completion of the interview. We conducted one interview in Arabic with the assistance of an interpreter.

We recorded, and later transcribed, all in- depth interviews and focus group discussions we developed a codebook for each component of the project using both predetermined codes based on study instruments and existing literature and emergent ideas. This allowed us to analyze our data for content and themes. We initiative analyzed each study component separately and in the final analytic phase we combined our findings paying specific attention to concordance and discordance. We used ATLAS.ti to manage our data and regular research team meetings, as well as engagement with an advisory group, informed our interpretation and recommendations. We present our results by theme and use illustrative quotes to support the findings.

We organized an advisory group of four women and gender non-binary identifying people (with lived experience of the VAW sector, violence, mental illness, and recovery) to review our findings and inform the analysis. We selected advisory group participants through various avenues, including advertising through the volunteer listserv at the Royal Ottawa Mental Health Centre, and communicating with VAW shelter staff and other community partners. This advisory group provided invaluable guidance and advice throughout the process.

## **Results**

### **Who were the Women we interviewed?**

All 30 women interviewed were fleeing abuse, either from family members or partners. The majority of participants were between the ages of 25 and 44 (70%), although 20% were older than 45. Two thirds of the women interviewed had children in their care at the time of the interview, 20% were caring for 3 or more children and another 20% indicated that they had at least one child who had been apprehended by the Children's Aid Society (CAS).

Women were diverse in terms of racial background; 27% identified as FNIM, 27% as Black, 20% as White, 13% as Arab, as 7% as Asian. Of the 30 interviews, we conducted six in French; 5 of these women were Black with African or Caribbean heritage and experiences of immigration. Participants also had varied educational backgrounds; 10% had less than a grade 8 education, 23% had completed some high school; 30% had completed high school; and 20%

had completed College or University. In terms of income, 47% received social assistance through Ontario Works and 13% received support through the Ontario Disability Support Program (ODSP).

Nearly three quarters of our respondents (73%) reported significant symptoms of PTSD, 60% reported symptoms of depression, and 33% reported symptoms of major depression. Ninety-three percent of women reported somatic symptoms, with 30% scoring in the high range. Women reported high levels of distress, although only 10% indicated they had ever received inpatient mental health care.

### **What did women say about their own mental health?**

Mental health is impacted by biological, social, and psychological factors. For women who have escaped violent and unsafe living situations, these factors often converge to create a complex web of experiences. Topical issues of substance use, somatization, abuse and gaslighting, loneliness and isolation, motherhood, and white supremacy emerged from our interviews. The women we interviewed were struggling with high rates of mental distress and symptoms of mental illness.

#### Substance Use and Violence

Various women described their mental health journey and experiences of abuse to be interwoven with substance use. In a few cases, their partner's substance use was recalled as preceding violence, and subsequently, both use and the violence intensified.

*"[H]e started drinking, and that is when the violence started kicking in, and that is when he started taking, uh, a drug called speed, that's what, that's what really did it. He put me in the hospital. He beat me up and he wouldn't stop..."*

Rhoda -Shelter resident

Frequently women who spoke about their own substance use described it as one of the primary ways they could forget or numb themselves from re-experiencing their trauma. Women frequently reported insomnia alongside other common symptoms of post-traumatic stress and intoxication served as one of the ways in which women coped.

For frontline staff, aggression related to mental health and substance use was frequently noted as a challenge. Staff recognized such behaviors as connected to trauma response, but nonetheless reported that they often felt a lack of capacity/resources to manage the substance use or underlying mental health struggles.

*"Their stay might be shortened because they are dealing with mental health and it's turning into aggression and what not and there is only so much that we can tolerate based on the number of children that we have here, so they can find themselves out of our door quicker than we would hope. For sure we find that often happens with mental health and addiction. And it breaks our hearts, women leaving the shelter prematurely."*

- Frontline Staff

### Somatization and the physical health impact of violence

Women reported high rates of somatization when completing the PHQ15. The women described, in order of frequency, headaches, insomnia, general body aches, weight gain, hypertension, acid reflux, and menstrual issues.

*“My ex keeps trying to contact me, he says he is sorry, that he will never do it, but he said that when he first hit me, when he first fought me...made me bleed my nose, but he wouldn't stop. That is when my headaches started kicking in, all the pain in my body.”*

Jody- Shelter resident

Women often reported seeking assistance for various complaints with primary health care providers, and it is unclear how often clinicians inquired about abuse and any possible somatic links to experiences of trauma. Women themselves were hesitant at times to make links between their mental health and somatic symptoms; the vocabulary of chronic pain was perhaps more accessible than that of mental health.

Staff noticed that women arriving at the shelter often referred to physical symptoms as related to their experience of trauma; of great importance then was the normalizing of women's physical and mental health symptoms as responses to abuse.

*“PTSD would also be [a common] one, and I think that's related to some of the behaviors like trauma reactions and people not really understanding their reaction to trauma, and us needing to do some normalization of what they are experiencing in their bodies physically and then also their emotions... like how it is related to flashbacks they are having”* – Frontline Staff

### Mental Health and Gaslighting

When asked about their mental health, several women associated anxiousness or depression with their abuser's repeated denigrations. We identify this phenomenon as gaslighting.

Women reported instances of being frequently told they were worthless and that they could not accomplish anything other than caring for their children (though at times women's parenting was also repeatedly criticized and undermined) and/or staying at home. This impacted women's perception of themselves, mental illness, and their capacity for resilience.

This self-doubt would play out in women's ability to make decisions, and result in several women considering a return to their abuser. Regardless of whether women had existing diagnoses of mental illness, abusers were reported to pejoratively use mental health labels, or terms such as “crazy” or “insane” to further degrade women's self-worth and confidence. For women with psychiatric histories, abusive partners would exploit their vulnerability by

threatening to institutionalize them, a situation which increased women's fear of the mental health system.

*"[J]ust before I left, I had him saying how crazy I was, how out of reality I was, how he would take me to the psych ward again. So, you know, all those terrible things... So I need someone to almost affirm that... You know sure you may have mental illness which I believe I have, but it doesn't mean that you've gone over the edge, you know? And that's how he made me feel. That I went over the edge."*

Kathleen- shelter resident

### Loneliness and Isolation

Loneliness and isolation played a major part in women's experiences of abuse, in their shelter experiences, and in their worries or concerns about moving into independent housing. Loneliness was often a contributing factor in a woman's inability to leave an abusive partner or family. Once in shelter, women described feeling isolated and alone, especially in the beginning before potentially fostering relationships with others.

*"And the mental health will bring isolation also, because a lot of times some of the women will choose to stay in their own rooms and not communicate with anybody except staff, or sometimes we have to go upstairs and check in."* – Frontline Staff

Finally, isolation and loneliness emerged often when women discussed leaving the shelter to live on their own. Contributing factors in this isolation included a lack of trust and a fear of feeling vulnerable with others, all traits common to trauma survivors. In interviews, women would consciously link loneliness and low mood to a desire for the familiar, and ultimately a heightened risk of returning to their abuser. As such, several women and all the frontline staff reported a desire for improved post-shelter and transitioning services into the community.

*"Oh god, I don't even know where to start. Like this is my first time living on my own. It's my first time being able to be a single parent and have my own space and not have anyone else living in the house to help me. So like I'm terrified"*

Astrid- shelter resident

### **VAW, Women, and Systems Interactions**

The in-depth interviews and focus group discussions illustrated the immense complexity of service and system interactions in the VAW sector. Women were potentially navigating many separate legal and social service oriented systems which included: family law proceedings, criminal justice related issues, immigration law, primary health care, mental health or substance use services, social assistance, and psychiatry or community services, such as counselling or case management. Separation from abusive spouses often required women to engage with social services, particularly around housing. Mothers often interacted with service providers for their children who might be in school, involved with child protection services, or connected to various healthcare services. This translated into frequent and varied interactions with multiple

service providers, all of which were frequently case managed to greater or lesser degrees by shelter staff.

### VAW Shelter Services

Women generally described an overall positive experience in VAW shelters. Words used to describe their experience included safe, stable, supported, friendly, and respectful. Some difficulties encountered by women in these facilities included loneliness and having to manage chaotic and/or triggering environments. Shelter staff clearly indicated that the communal living environments of the shelter posed specific challenges for women, especially those with addictions and mental health concerns. Since children were present in all shelters, VAW shelters necessarily maintain a low threshold of tolerance for unsafe behaviors and substance use. Only some women could manage the VAW shelter setting; others were referred to homelessness sector services.

*“At my pace, [the VAW shelter] was slower when I first got here but now that I’m happier, my kids are happy and it has been a long time since I have felt really down because of my abuser, and I haven’t talked to him in a while which is a good thing. It wasn’t such a good thing for me in the beginning, but now I am getting used to it and now I am realizing like there’s so much more than what I had before.”*

Charlene- shelter resident

Most of the women interviewed stated that the first few weeks were very challenging as they adjusted to a new living situation while dealing with the trauma they had experienced. After a period of adjustment, they were very grateful for the shelter. Many women noted that without all the support of the staff and the other women they would have returned to their abuser. Staff observations point to the successes and great importance of these services. Several women praised the child minding services offered in shelters and the privacy of having their own rooms.

Women with pre-existing mental health challenges described different experiences of VAW shelters than those without. Women discussed how the shelter staff were a good source of support and adept system navigators, but were unable to give them the quality of mental health support they required. One woman specifically noted, “I like counselling, but I prefer counselling due to mental illness. I prefer that because I feel I’m more understood.” In this case, access to registered health professionals was also a source of comfort and safety to women.

This sentiment corresponds to difficulties identified by VAW staff. They reported that the overwhelming caseloads of VAW outreach workers, the dual frontline role of both supporter and arbiter within a communal living environment, a lack of knowledge or confidence with regard to mental health, and a lack of system integration with other mental health services can compromise the VAW shelter system’s ability to adequately address issues of mental health.

*“[W]hen you come here as a person, you find the safety, you have a bed, a room to sleep, a number to call. But, you can’t feel peace. They give you a support, they give you.,warm feelings, a push for the beginning, but you can’t feel peace because nothing [is] fixed outside.”*

Janine - shelter resident

### Peers and support

When asked, “who are your supporters?” and “what improvements would you like to see in shelters?”, many of the VAW shelter residents indicated that one of their main sources of support were the other women in the shelter. Many wanted more support groups and workshops with the other women. The sense of solidarity obtained from interactions with other women in the shelter offered much needed validation. Peer support functioned as an antidote to the self-doubt and gaslighting that accompanied experiences of abuse; it helped the women see themselves differently and to “not feel crazy”.

*“When I come here I never expected what I have here in a sense that I never knew, you know I was thinking okay something is wrong with me. So coming and meeting other women who go through the same trauma that I was going through makes me to say “Oh, you are not crazy”. So, then sitting with the women, some of them just talking, seeing that all of you have something identical and common you don’t need to do anything before an abuser launch on you, then it helps you remove some of the guilt that “Oh, I was the problem” or something. Just help me say okay I was not alone”*

Isa- shelter resident

Due to the controlling nature of abusive relationships, many of the shelter residents had been prevented from developing and maintaining friendships. When asked who their supporters were, many women indicated that they had none; many women did however develop friendships in the shelter and residents noted that these were immensely nourishing and valuable. Shelter staff noted that several women made lasting friendships that offered them hope alongside tangible supports after leaving the shelter. Staff confirmed that women who were able to make friendships in shelter often were more successful once housed in the community.

Women residents of Maison d’Amitié spoke very fondly on the Wednesday night group in which staff, residents and recently housed ex-residents could get together to discuss and review various topics related to surviving and moving on after abuse. Groups, and sometimes spontaneous gatherings as well, offered women an opportunity to reflect on and address their mental health difficulties.

*“I worked evenings here for a number of years back in the day, and the best times were when the kids went to bed, someone wanted to bake a cake, or something, I remember lots of cake, lots of coffee and tea, lots of laughter and cheers. Like it was 11, 12 o'clock at night and we sitting around a table and doing what women do best, supporting each other, and some of the things that were shared around that tables would make your*

*head spin, but it was healing for everyone, like “Oh my God, me too”, those me too moments were endless, and the best time. The best part of my job was seeing women come together like that” – Frontline Staff*

### Barriers to disclosure of mental health difficulties

Women’s willingness to discuss mental health varied and appeared to be influenced by a number of factors. In general, older women with grown children were more open and forthcoming than younger women with small children. Stigma and fear were cited by several women reasons for non-disclosure. Examples included fear of losing their children to CAS, fear of deportation if mental health issues were disclosed in the midst of immigration proceedings, fear of judgement by health care practitioners, and fear that their mental health issues would be used against them in the family court system. These concerns were connected to a lack of trust in the system, lack of trust in confidentiality, and sometimes in a history of difficult interactions with service providers. Such traits and perspectives are frequently and understandably shared by survivors of trauma.

*“It’s very difficult to talk about this stuff because of fear. You’re afraid of what’s going to happen to your child. Are they, you know, is CAS or somebody else going to say you’re not competent to be a mother? Or sometimes what you’re feeling is truly horrible but you would never act on those feelings or thoughts but just to be able to feel like safe to tell someone? And like, is it truly going to be confidential? You know, because of dealing with custody and other things, like all of that stuff will get used against you. So, it’s very hard. Like, I should have gone in to see a therapist or a doctor or anybody for my postpartum depression after he was born when he was a couple months old. Like, things were really bad for a bit but I didn’t go because I was so afraid of what would happen.”*

Julie- shelter resident

As reported, these factors were enough to make women silent in and of themselves; of further concern however, they also often lacked the mental health vocabulary necessary for effective self- advocacy. For instance, when directly asked in interviews about their mental health, many women responded by asking what mental health was, or stated in essence that they did not feel qualified to answer. Nonetheless, they proceeded to describe symptoms that were suggestive of depression, anxiety, and/or PTSD. A few women did also report mental health difficulties, but emphasized that other women’s conditions were far worse, effectively serving to deflect from their own struggles.

Some women noted that they refused to “give into” their mental health struggles because they had to “stay strong for their children”. From this perspective, acknowledging mental health struggles was sometimes seen negatively, as something against which one had to deflect and defend.

*“There’s a fear that any diagnosis will impact their custody or access to their children, so there is certainly, yeah there is that side of it too. Some women may identify or recognize that they have some really difficult stuff that they are going through but they don’t want to*

*seek help because they are worried about how it will play out in court. Because their abusers, it is something that, it's like this thing that abusers learn in abuser school like to call their partners crazy and that sort of thing so then the fear of actually being diagnosed with something is pretty intense.” – Frontline worker*

#### Mental health services missing the mark

The women who access VAW shelters have experienced abuse and violence in a myriad of different forms and settings. These experiences of trauma created and/or contributed to a series of highly complex mental health issues. The mental health service interactions described by women in VAW shelters portrayed a repeated failure to respond with a trauma-informed lens or with effective interventions. This is in part due to the fact that helpful psychotherapeutic treatments are not typically covered by the Ontario Health Insurance Plan (OHIP) and are available only in piecemeal fashion in the community. While the Increased Access to Structured Psychotherapy program has made some efforts in this respect, it is designed to support people with single incident trauma only. As such it may not apply to women survivors of violence with more complex presentations.

*“because I don't have money and like, my family has never had enough money to pay for somebody, I've never been able to have a consistent person working with me and that's made it very difficult and discouraging to even bother getting help. Because if you're constantly seeing different people, they don't really get a good picture of you, you know? Like, even if you're trying your best to communicate well with them, it's still hard because different people have different perceptions, right? And even professionals who are doing their best still have a hard time getting to know somebody, um, over a short period of time, right?”*

Carol- shelter resident

When discussing interactions with healthcare providers, many women noted that they were offered primarily pharmacological treatment options. Unfortunately, this did not necessarily accompany psychiatric evaluation; very rarely did women have regular mental health follow-up, especially from a psychiatrist. Shelter workers noted that women who came to shelter already connected to services, such as the Canadian Mental Health Association's (CMHA) case management, did far better when in shelter than those without mental health supports. Waitlists for these services are several years long and shortages in the availability of mental health care has proved to be a significant problem

Women expressed that generally primary care providers did not have the time necessary to sort out their unique and complex situations in the space of a fifteen minute session. Also women alluded occasionally to a lack of trust surrounding confidentiality with respect to health care providers. Members of our research advisory committee with lived experiences of these systems, as well as VAW shelter frontline staff, indicated that mental health diagnoses were at times used against women by abusers, in family court scenarios, and by the Children's Aid Society. In these situations the combination of system pressures surrounding time for primary healthcare appointments, difficulty accessing comprehensive mental health care, and the

agendas of child protection services and custody proceedings create a hostile environment for women's disclosure of mental health concerns.

*"I've gone into places [and] they just want to prescribe me pills., which I think are a very useful tool, but I just don't think [that's] what I need right now in my life. I think I just need somebody to stay a consistent person to talk to me and help deal with things and not just what I'm going through now, but from my past that led me to this point now. You know there's a reason why I've been in abusive relationships; it's not because everything in my life was so wonderful and I had such a great...you know self-esteem and such great mental health to begin with that I like fell in with somebody bad, you know?"*

Meg- shelter resident

For a few women it was difficult either to relate to case managers, social workers or counsellors accessed in the community; services were frequently mandated to a specific worker with whom they may or may not feel connected. In the event that they did find a worker they could access and relate to, time-limits often required services to end too abruptly or prematurely. While a few women had successfully accessed psychiatrists in the community, several others who attempted to seek out psychiatric care were simply put on lengthy waitlists, or received only one time consultations with minimal follow-up. Staff and residents alike noted incidents in which suicidal women presented to emergency rooms and were often turned away as their crisis was not seen as severe enough to warrant hospitalization. In general, both women and VAW staff noted a need for more consistency and follow-up with regard to psychiatric care.

*"Yeah, my doctor said it would take me over a year on a wait list to be able to speak to somebody and he didn't even want to sign me up because he was like it's pointless, it will take too long. So, and being that I'm not very good at asserting myself with men to begin with, I didn't even push the issue and I tried multiple, I've like gone into him multiple times before even coming here to say like "Hey I really need to speak to somebody" and he just didn't really want to put me on the list. But if he'd put me on the list, that was more than a year ago, I'd probably be able to speak to somebody now."*

Amy- shelter resident

#### Gaps between Mental Health Services and the VAW sector

The frontline staff clearly indicated that they felt they needed more support, both in the form of education and access to mental health services for their clients. These staff often arbitrate the parameters of communal living and encourage women to meet program requirements. The power dynamic that emerges between staff and residents hinders the ability of staff to effectuate clinical interventions with women who do not feel comfortable sharing mental health concerns with staff. For instance, one staff member recounted how a woman spoke to her for hours one evening about her anxiety surrounding the filling out of forms and organizing housing. The next day the staff member, as part of her job, had to remind the woman that it was her last day to hand in her housing forms. This situation was difficult for the staff person and left them feeling at a loss in terms of how to adequately support the resident's mental health difficulties.

*“It’s just there is also this dynamic with staff and residents too because the staff it is their role to make sure that the house is, you know, there is order, and that chores are being done, and people are cleaning up after themselves and so, sometimes it is hard to have that relationship on the one hand and to support someone with their mental health on the other hand because they can conflict, which is why it would be so important to have a worker dedicated to that.” – Frontline Staff*

VAW shelters, unlike homeless shelters in Ottawa, do not have a dedicated mental health outreach worker. Shelter staff noted that this sometimes resulted in shelter staff actually sending some women to homeless shelters just so they could access mental health services there. Such a situation is unfortunate given that many homelessness sector services lack the contextual awareness of the VAW sector, the same level of specific systems knowledge, and are certainly not an option for women with children in their care. For mothers struggling with their mental health while in shelter, this lack of mental health support has the potential deleterious effect of further mental health decompensation, potential child apprehensions and possible homelessness for the mother thereafter. The moment of respite potentially created by the VAW sector then serves as an opportune time for mental health intervention, and an opportunity for preventative care that is currently overlooked.

Another gap frequently highlighted by shelter staff identified a need for services between the VAW and homelessness sectors. Staff identified that for women who struggled in the communal living environment, often due to their mental health or substance use, the homelessness sector services were not a better or more desirable option. Instead at times the homelessness system was highly triggering, and lacked the same kinds of supports offered in the VAW context. Having one VAW shelter devoted for instance to the needs of single women, without the consistent presence of children, might more easily facilitate an implementation of harm reduction principles without the same levels of risk.

*“And even when we end up sending women, single women with some mental health issues to a women’s shelter I personally get really happy because they get so much access immediately that they do not get at our shelter. Yes there is this thing of living in a homeless shelter versus a VAW shelter right, there is that peace, like the access to services. And unfortunately at that point they have lost their children, like they can’t have their children at Cornerstone.” – Frontline Staff*

Residents and staff when interviewed noted a lack of mental health support for women once they are housed outside of the shelters. Not only do VAW shelters and community organizations lack the capacity for psychiatric assessment, but also for the more intensive case management assistance sometimes necessary in cases of persistent mental illness. While at least some shelters do have designated transition support workers, the scope of their role and the immensity of their caseloads prevent the kind of accompaniment sometimes required. While women in homelessness sector shelters would access housing first initiatives that include some support when people leave shelter, women in VAW sector shelter do not. An expansion of this service would be helpful.

*“We don’t have the capacity of a CMHA worker who can pick somebody up from their house take them to this appointment, take them to that appointment, make sure that they get enough groceries for lunch or dinner, and then take them home. We don’t have the capacity or the time to meet all of those needs for people. So a lot of the time we are sort of sending people with huge anxiety issues to the bank to go and do these things on their own, which can be debilitating to that person, and at the same time sort of saying you have to do this, you need to be doing this, but I don’t have the support to be the person to do it”- Frontline Staff*

### **Motherhood, CAS and Mental Health**

In-depth interviews and focus group discussions revealed motherhood as a recurring theme in relation to mental health. Overwhelmingly women’s commentary on the impact of motherhood on their mental health in the VAW context was mixed. While there was a noted tendency for women to rise to challenges and push through difficult circumstances for their kids, separation from children (due to CAS intervention or the circumstances in which women fled violence), was an immense source of distress affecting mental health. Often mothers described the presence of children as a source of strength and comfort and for some a motivating factor to seek help for mental health difficulties.

*“I should have gone into see a therapist or a doctor or anybody for my postpartum depression after he was born when he was a couple months old. Like, things were really bad for a bit, but I didn’t go because I was so afraid of what would happen. And I don’t know if that’s anyone’s fault per se, but just... that’s something I think that needs to be worked on because I think... they warn you about postpartum depression and they give you all these resources and tools, but you still just don’t really feel comfortable because you’re so worried about your child being taken from you; to be honest”*

Karen- shelter resident

Several women reported postpartum depression (PPD) symptoms, which rarely received treatment. Mothers reported that in general they spent more time attending to the mental health needs of their children than their own. Some women spoke of pressures they felt to be perfect mothers. This also had the potential to be used against women by abusers who in some instances criticized women’s mothering as a point of manipulation and control. Many women also reported that they did not seek help from shelter staff or from other services, choosing instead to manage mental health difficulties on their own. This was a natural response to concerns women had about their mental health records being used against them in the context of custody and access disputes. As such, Children’s Aid Services (CAS) involvement had a substantial impact not only on a mother’s mental health, but also in her sense of safety in accessing services.

It is noteworthy that some participants connected to shelter services and got out of abusive relationships precisely because of assistance/ motivation from CAS. Unfortunately, in some of these same instances CAS apprehended children citing that moving into shelter is a difficult

transition to which children should not be exposed. For these women the process was extremely difficult and in some cases caused them to feel like they had made the wrong decision in fleeing. These types of interactions with CAS unfortunately led women to have increased self-doubt, declines in mental wellness, fear of service providers, and ultimately unwillingness to disclose mental health concerns. In the cases of Indigenous women, these apprehensions served also as a stark reminder of the ongoing genocide of Indigenous peoples.

For women with precarious immigration status, CAS constituted a point of scrutiny, which could leave women vulnerable to deportation and further risk in their home countries.

*"I called CAS myself because I had to. Because I went into family services; my son's dad now is trying to use CAS against me by getting all of his friends to call and make anonymous claims about me and my mental health and how I'm not fit to have my baby, which is incredibly stressful, ...when he gets his friends to call, they immediately, within a day, come to check if I'm a good enough mom. You know, so I don't feel like they're there to really help me... you know? We're here every day doing our very best to take care of our babies, like, and yea, of course we're going to be emotional sometimes, but that doesn't mean we're bad people or bad parents and yeah, abusive people who don't have the same emotion or feeling they're great at pretending like they're so stable and wonderful. That's the whole thing, and it makes them seem like they're so much better than they are, and it also makes it that much scarier for us to want to go and get help for our mental health because they're using that against us already, you know."*

Laurie- shelter resident

When the women spoke about motherhood it was often cited as a reason for not accessing mental health services. Several women stated that they would not report mental health issues because they had to stay strong for their children. As such, while children are an undeniably important factor in the resilience of women survivors of abuse, the systemic pressures surrounding motherhood also serve to prevent them from addressing their own mental health concerns. .

### **Racialization, White Supremacy, and Mental Health**

White supremacy emerged most notably through women's experiences of immigration and indigeneity. Racialized women presented qualitatively different experiences of violence, sequelae, and faced unique barriers. These women routinely faced extra barriers and difficulties related to the pervasiveness of white supremacy ingrained into the structures of service provision.

#### *First Nations, Inuit, and Métis Experiences of Mental Health*

First Nations, Inuit, and Métis (FNIM) women overwhelmingly recounted stories of displacement from home communities to reach urban centers in order to either access appropriate services and/or for safety reasons. This displacement, while garnering the women necessary services, unfortunately served to isolate women from the cultural heart of their nations which might include traditional land bases, languages, cultural practices, as well as community and family.

In this sense, a lack of services and safety in remote communities perpetuated colonial agendas of cultural assimilation, now more commonly and openly discussed as cultural genocide (NIMMIWG, 2019).

Accompanying these stories of displacement was a qualitatively different experience and intensity of trauma, which served as a distressing testament to the ways misogyny and white supremacy intersect to generate increased exposure to violence and risk of death for FNIM Women in Canada. Many of the FNIM women interviewed described “freezing” or having “seizures” when reminded of past violence, alongside other symptoms of trauma response.

Unlike non-Indigenous and immigrant women, many of the Indigenous women described pervasive or repeated violations and traumas from multiple aggressors. One woman described multiple exposures to predatory behavior throughout her childhood. She elaborated on one particular incident that occurred while she was a teenager:

*“He came specifically from Sudbury to this little town to nab a native. He was known to go after natives...Native women...This big lug of a White guy just like trying to intimidate me and get me in his car, pay me, and get out of here. First you offer me weed and drugs...“I got some coke, if you want some just get in the car”... I was like ‘oh my god this guy’s a...you know?’”*

Cindy- shelter resident

Despite her refusal, he later tried to physically assault her, but she escaped. Later in the interview, she noted “this is probably going to be the first year I have yet to have someone try to do anything. So I’m hoping it passes and keeps going. ” This gestures to the widespread violence to which Indigenous women are subject in Canada and was reflected in other FNIM interviews as well. For FNIM women, more than other populations, violence was not only a threat from identified abusers, but also from a colonial culture of predation that views Indigenous women as appropriate targets.

#### *First Nations, Metis and Inuit experiences of service Provision*

While First Nations, Metis and Inuit women are subject to violence within as well as outside of their communities, some women described a clear lack of support at times in their home communities, from friends and family as well as from service providers. For FNIM women more than any others, relationships with police were also noted as a challenge. Several women described that when they called police in crisis in their home communities they received either a delayed or non-existent response. One woman described an incident in which she called in the midst of an assault and was told to call back when she was sober.

Such circumstances illustrate that state administered services, while outwardly intended to administer supports to all citizens, including FNIM women, can also operate precisely as the means through which legacies of assimilation, genocide and neglect continue to operate.

In remote communities several generations of assimilatory policy has resulted in a dysregulated conceptualization of safety which extends also beyond service providers. Another woman

explained that when she was being assaulted in her community, she would scream loud enough for several neighbors to hear but no one would ever come to check on her. Most distressingly she described a moment where police services and others saw no reason to intervene in her physical abuse. When she moved to Ottawa and was unfortunately pursued and assaulted by her abuser, she screamed and four neighbors showed up at her door to help. She expressed reassurance and comfort in this response. While this anecdote highlights a sense of safety once in an urban center, it is worth noting too that even as islands of safety are created away from remote communities, there is still dislocation and loss in this separation.

Women did frequently discuss movement from remote areas to urban centers, but did not generally want to distance themselves from their sense of Indigeneity, or their culture. Most of the First Nations, Inuit and Metis women interviewed in the study were residing at Ottawa's only FNIM women's VAW shelter. These services were deeply valued by women and well utilized; of particular noteworthiness were the abundance of services, support, and the VAW awareness/lens. Highlighting the importance of Indigenous led services, one woman explained that she had chosen to be homeless rather than go to a non-indigenous shelter because her previous experiences had been so negative and triggering of her past trauma.

*"And I felt like they knew where I was coming from, like my history and everything. They only knew part of it but they could... kind of relate to me. You know it just feels more comfortable to talk to leaders about the residential [schools] and they'll understand "oh yeah, that area got that a lot too, yeah I can see why you"...you know?"*

Elsie- shelter resident

While legacies of intergenerational traumas were clearly articulated as women responded to interview questions, so was the sense of solace provided by Indigenous cultures and cultural activities. Talking with elders and crafting (beadwork, moccasin making, etc.) were all noted again and again as important coping strategies for women looking to feel more grounded in the wake of trauma. Stories told by Indigenous women frequently noted issues of child apprehension, difficulty with CAS, high rates of violence and exposure to predation, struggles with substance use (perhaps their own or their partner's) and reported that all of this was detrimental to their mental health and recovery from abuse. It was notable that nearly all the FNIM women interviewed reported that they had at some point lost children to child protection services. One clear barrier to care was the way in which services at times replicated or evoked the institutionalization and corresponding trauma of residential school (especially shelters and treatment centers). The importance of Indigenous led and culture based programs were thus highlighted by FNIM women as central to the provision of safer and less traumatizing services.

#### *Experience of Immigration, Violence, and Mental Health*

Immigrant Participants in the study did not present as a particularly uniform group. These women had more difficulty relating to the language of "mental health" and often reported a lack of familiarity with the subject. Nevertheless, women completed self-report questionnaires that revealed generally significant symptomatology. Many were reserved to greater or lesser

degrees when it came to discussing their mental health, while a few endorsed mental health diagnoses, or difficulties, and were able to describe and discuss them.

Women with experiences of immigration often described scenarios of profound isolation. They reported abusive situations not only from their spouse, but also from their families and/or in-laws. Once they had fled, women were often without support systems. This, combined with the complications of understanding unfamiliar cultural customs, language barriers, and racism put women in very vulnerable positions. Some spoke openly and without constraint in the interviews, while others struggled with the interview process.

*“[M]y experience is pretty bad as a victim of abuse. My abuser he even took all my personal belongings in that...in that way I lost everything, I lost my status, everything...Because he took my passport, my working permit..., and that way I can’t get anything...”*

Aashrita - shelter resident

Regardless of mental health, survivors with experiences of immigration described scenarios of white supremacy, racism, sexism and motherhood as forces that intersected in complex ways. Sexist policies or abusive situations in home countries pushed women to leave with, or sometimes without their children. In general, it was clear that a lack of support, fear of impact to immigration status and a lack of knowledge about social norms, laws and services here in Canada contributed to abusive situations.

Overwhelmingly, women with experiences of immigration expressed an almost total lack of a support system. Notably, the only Francophone VAW shelter was used predominantly by and black immigrant women. These women faced barriers not only concerning racialization, but also surrounding the lack of French language health care, especially primary care, available in the Ottawa area.

*“Most of us are dying in silence and most of us cannot even say what we are really thinking or what we are really going through because of the fear. Like I told you, right from the hospital I was at, they called the CAS. I didn’t even know what the CAS means because we never have such in my country. And when I was in the U.S., I was mostly underground. I didn’t want the government to know I was there because I was risking deportation and...so, I couldn’t really – so here, when they told me “child support,” I was like, “What does that mean?” Until it was explained what it is, I was like, “Oh, my God.” Right there I was scared.”*

Chinara- shelter resident

This experiencing of compounding barriers could be traced throughout the stories of the women immigrants interviewed. Women indicated that their immigration status would complicate their ability to leave abusive relationships, and at times was used against them by abusers. Other complicating factors included family or cultural pressures, access and custody of children, combined with a lack of mental health literacy and awareness regarding gender based violence.

These extra layers of vulnerability translated also into difficulties or complications with service providers. One woman with no support and limited ability to speak English, was advised by a police officer to stay overnight in a hospital waiting room as no shelter space was available for her. Interactions such as this may point to a potential overburdening of systems, but also demonstrate an unwillingness to make more appropriate and potentially successful referrals. While such a scenario is undoubtedly difficult for any woman to navigate, the task becomes gargantuan when negotiated through unfamiliar cultural customs, racism and language barriers, and no support.

## **Discussion**

Interviews and focus group discussions clearly demonstrated the need for, and value of, VAW shelters. Women are frequently turned away due to a lack of beds, a reality reflecting not only an unfulfilled need, but also the established trust that women have placed in this service. Residents frequently indicated that the child minding services offered crucial support, that staff were attentive and helpful, and for the shelters with explicit peer-style support groups, this was identified as a transformative experience and a highlight for women. For the First Nations, Inuit and Metis women who accessed Oshki Kizis, Ottawa's only Indigenous VAW shelter, the presence of an Indigenous run service was immensely valued given the history of colonial violence in Canada and its operationalization through social services, education and health institutions. Overall, the VAW sector offers women an opportunity to collect and rebuild after experiences of trauma. It is also opportune moment for appropriate mental health intervention.

The issue of the pervasive stigma that surrounds mental health challenges and diagnoses often emerged from the data; a force that unfortunately play out to the advantage of abusers within the context of abusive relationships. The reduction of stigma more generally through education and awareness reduces the power these sorts of mental health labels can have within these relationship dynamics.

Beyond stigma, interviews and focus group discussions pointed to a lack of accessible diagnosis and treatment, particularly for trauma. These gestured to a two-tiered healthcare system where low-income people without workplace insurance struggle to access psychotherapy. Free and low fee services are frequently only available at community agencies that will offer a limited number of sessions and may not be able to offer the most appropriate psychotherapeutic modalities for unresolved or complex traumatic stress. such considerations are crucial given that economic pressures are unfortunately common for women survivors utilizing shelter services. Further, PTSD is common among survivors of violence as 22% of women experience symptoms from within all three symptom clusters as outlined in the DSM IV (Burczycka 2014).

While women are often hesitant to discuss mental health and trauma within the context of care (whether healthcare, CAS or otherwise), systems would also benefit from a more trauma

informed approach. This should be supplemented with knowledge related to the experiences of immigration and of the history of genocide against First Nations, Inuit and Metis people in Canada. This point warrants particular consideration given that assimilatory policies were executed specifically through education, healthcare and social service systems. In addition to a general need for trauma informed practice with Indigenous populations, there is also a concrete need for more services in remote First Nations, Metis and Inuit communities (NIMMIWG, 2019).

For recent immigrants, further/ continued education to newcomers concerning legal rights in Canada, and a general adoption of a sanctuary city philosophy with regard to municipal services can help keep undocumented women and children safer and less fearful of engaging with police, or other services (Ardanaz, 2017). Better access to French language healthcare and multilingual services are also important in reducing vulnerabilities for these populations of women.

We chose to draw on the concept of white supremacy as a catchall for the various themes involving race on recommendation from our advisory group. As described by author and cultural critic bell hooks:

“an important break through, I felt, ...was the call to use the term white supremacy, over racism because racism in and of itself did not really allow for a discourse of colonization and decolonization, the recognition of the internalized racism within people of color and it was always in a sense keeping things at the level at which whiteness and white people remained at the center of the discussion” (1997, 7).

It is notable that two-thirds of the women interviewed for this study identified as being part of a racialized group. When compared with Ottawa’s general population, this constitutes an over-representation of racialized women in the shelter VAW shelter system. This suggests a trend given that “[i]n Canada 54% of Aboriginal women reported severe forms of family violence compared to 37% of non-Aboriginal women, and other racialized women suffer greatly from domestic violence” (Abban 2013). The *Interim Report on Missing and Murdered Indigenous Women and Girls* indicated that Indigenous women in Canada were more likely to be victimized; seven times more likely to be killed by a serial killer, will live with higher and more severe rates of IPV, and experience higher rates of mental health difficulties and suicide (NIMMIWG 2017;9).

Numerous studies have confirmed that the experiences of violence, and compounding system pressures (such as those noted above), that preceded women accessing VAW shelters are highly correlated with mental health issues, predominantly mood and anxiety disorders, including PTSD, and substance use disorders (BCSTH, 2011). Unfortunately, for a number of historic, bureaucratic, and philosophical reasons, there is a lack of integration between anti-violence, mental health, and substance use sectors (Mason & Toner, 2012). The Ottawa region is no exception in this.

The Ontario Ministry of Community and Social Services (MCSS), which funds VAW shelters, has developed VAW emergency shelter standards. Specifically, the standards state that

shelters will provide access to all women and dependents seeking shelter services, including women who use substances and those with mental health needs (MCSS). A scoping review of published studies exploring co-occurring intimate partner violence, mental health, and substance use problems reported that “front-line workers in all three sectors... state they lack the training to address these co-occurring problems” (Mason & O’Rinn, 2014)). One Ontario study of anti-violence workers found that a third of study participants reported fair or poor competence levels in dealing with both substance use and mental health issues (Purdon, 2008).

Literature on the subject illustrates a failure to fully address the mental health issues experienced by women in VAW shelters. Nonetheless, we see many deleterious impacts for them and their children; this includes: losing custody of their children, increasing their vulnerability to experiencing more violence by leaving the shelter prematurely, and increasing their level of disability due to a lack of timely treatment (BCSTH, 2011). Certainly, this bore out in the stories shared by women participating in our study. Women finding themselves in the more vulnerable social and economic positions outlined above might easily face a downward trajectory after, or during, a stay in the VAW shelters. As such the following recommendations emerged from the data to characterize some of the changes women would like to see in the VAW sector.

## **Recommendations**

### Mental Health Outreach and Education: VAW Psychiatric Outreach Service expansion

The presence of a third party in the form of an outreach worker specializing in mental health is needed; both to offer clinical intervention with the resident, and to take on a consultative role with staff. Staff and residents, especially those with pre-existing mental health struggles, expressed their desire for a VAW sector outreach worker. The discrepancy in services between the homelessness and VAW sectors can be addressed by expanding the current services of the Psychiatric Outreach Team for homelessness sector organizations to include VAW shelters.

The value of the psychiatric outreach team’s current model lies in its amalgamation of clinical intervention, consultation with staff of partner agencies, and its provision of mental health education. As outlined above, having access to such a team of registered health professionals would effectively address many needs identified by residents and staff. Within this, staff noted that access to feminist oriented psychiatry would be important. Staff of the Indigenous women’s shelter indicated that an outreach model serves as a useful intervention model for working with Indigenous people who may experience discomfort in more institutional settings due to the trauma and nature of genocide in Canada.

### Peer support is essential: more intentional and organized peer oriented programming in VAW

More peer-led, or peer informed, styles of programming are needed in shelters. This has the potential to mesh well with psychiatric outreach services, which might assist women to stabilize enough to effectively engage with their peers and VAW staff. These peer-style interventions demonstrate the feminist philosophy and approach that in many ways separates VAW sector

services from those of the general homeless population. In essence, these modalities offer more explicitly trauma informed and feminist care to women.

Since 2013 the Women's Mental Health program at the Royal has incorporated peer support into the services offered. This has consisted of various therapeutic/ psychoeducational groups, which peer volunteer run. Our own evaluations have demonstrated that women had higher self-reported recovery scores after engaging in groups than prior (O'Brien & Magner 2015).

### **Conclusion**

Throughout this report we have endeavored to illustrate 1) the mental health difficulties of women in VAW shelters, and 2) the high degree of complexity with regard to their interactions with services in the community. In so doing, this document has made recommendations that might facilitate advocacy for equitable system access to mental health services, while simultaneously providing an educational resource that might well serve mental health professionals less familiar with the VAW sector.

By recommending that the psychiatric outreach services expand to the VAW sector, we hope to facilitate an improvement to VAW shelter resident's access to mental health services. We see too that an intentional fostering of peer support oriented initiatives might serve to counter balance and soothe many of the harmful impacts of abuse resulting traumatic response. It is our hope that this strength can be given space to expand and flourish, something that might be more accessible to all women after receiving any potentially necessary mental healthcare. While systemic pressures will unfortunately continue to negatively impact women, these adjustments to the already excellent VAW services would better serve residents. Rather than continuing on a potential decompensation toward child apprehension, further mental health decline, and future homelessness, early mental health intervention might offer women a better and more comprehensive roadmap toward recovery.

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## **Appendices**

### **Appendix A**

Exploring the Mental Health Needs of Women Residing in Violence Against Women Shelters in  
Ottawa, Ontario, Canada

In-depth interview guide

Thank-you for agreeing to participate in this interview today. My name is Ann-Marie O'Brien and I am a social worker, and the lead for Women's Mental Health at The Royal. Women's Mental Health is part of the Community Mental Health Program at The Royal. We are collaborating with all Violence Against Women shelters in Ottawa, to explore the mental health needs of women residing in VAW shelters. We are also interested in shelter staff's perceptions of the mental health needs of residents, and their experiences in advocating for access to mental health services/supports. Our project is being funded by the Women's Xchange at Women's College Hospital.

Please take a minute to review our consent form. I'm happy to answer any questions.

The goal of our study is to produce a report on the mental health needs of shelter residents.

1. Could you tell me a bit about your mental health challenges?
2. Could you tell me a bit about your support system? Who are your supporters?
3. What has been your experience accessing mental health services/supports?
4. How have things been since you've been in the shelter?
5. How do you feel your mental health needs have been addressed in the shelter?
6. What do you think would help?

Version June 2, 2018

## Appendix B

### Consent Form

#### Exploring the mental health needs of women in Violence Against Women Shelters

Women's Mental Health is part of the community Mental Health Program at The Royal, in collaboration with Violence Against Women shelters in Ottawa, is exploring the mental health needs of women residing in VAW shelters. We would like to invite you to participate in this research project. Our goal is to produce a report card on the mental health needs of women in VAW shelters and to use this information to advocate for mental health services. This project had been funded by the WomensXchange at Women's College Hospital in Toronto. Over the next few months we will be meeting with women at each of the 6 shelters in Ottawa to examine women's mental health needs, and experiences in accessing mental health services. We will also be speaking with shelter staff on their experiences with addressing mental health issues. If you **choose** to participate you will be invited to join a focus group discussion, as well as complete questionnaires, and have an interview with a researcher.

The project will be conducted in either English or French, and other languages as required.

Discussing mental health issues may be distressing for some women. We encourage you to use your supporters. In participating in this study you are helping to develop knowledge to advocate for better mental health services for women.

You are under NO OBLIGATION to participate, and you are free to withdraw at any time. Participation will not affect services received at any other agency. If you do participate we will keep you informed of the progress of the study. You will not be identified as a participant. All information collected will be kept confidential. We are only interested in looking at collective information - that is information from all the participants together, not an individual's information. The only people who have access to the information collected is the research team: Ann-Marie O'Brien MSW RSW, and Dr. Angel Foster.

Participants will be compensated for their time with a 50\$VISA gift card.

The principal investigator is Ann-Marie O'Brien, and she can be reached at [ann-marie.obrien@theroyal.ca](mailto:ann-marie.obrien@theroyal.ca) 613-722-6521 x 6879.

I have read, and understand the proposed study, and I will consent to participation:

Name:

Date:

Version June 2, 2018

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Français

## Formulaire de consentement

### Explorer les besoins en matière de santé mentale des femmes dans les maisons d'hébergement pour femmes victimes de violence

La santé mentale des femmes fait partie du programme de santé mentale communautaire du Royal qui, en collaboration avec les maisons d'hébergement pour femmes victimes de violence d'Ottawa, examine les besoins en matière de santé mentale des femmes habitant dans les maisons d'hébergement pour femmes victimes de violence. Nous aimerions vous inviter à participer au présent projet de recherche. Notre but est de préparer une fiche de rendement sur les besoins en matière de santé mentale des femmes habitant dans les maisons d'hébergement pour femmes victimes de violence et d'utiliser cette information pour promouvoir les services de santé mentale. Le projet est financé par le WomensXchange de l'hôpital Women's College Hospital à Toronto. Au cours des prochains mois, nous rencontrerons des femmes dans chacune des six maisons d'hébergement d'Ottawa afin d'examiner les besoins en matière de santé mentale des femmes et de connaître leurs expériences quant à l'accès aux services de santé mentale. Nous parlerons également aux employées des maisons d'hébergement au sujet de leurs expériences relativement au traitement des problèmes de santé mentale. Si vous **décidez** de participer au projet, vous serez invitée à participer à un groupe de discussion, remplir un questionnaire et passer une entrevue avec un chercheur.

Le projet sera réalisé en anglais ou en français, et en d'autres langues, au besoin.

Discuter de problèmes de santé mentale pourrait être bouleversant pour certaines femmes. Nous vous encourageons à faire appel à vos soutiens. En participant à l'étude, vous aidez à approfondir les connaissances dans le but de recommander de meilleurs services de santé mentale pour les femmes.

Vous n'êtes PAS OBLIGÉE de participer et vous êtes libre de vous retirer du projet en tout temps. Votre participation n'aura pas d'incidence sur les services offerts par un autre organisme. Si vous décidez de participer au projet, nous vous tiendrons au courant du progrès de l'étude. Vous ne serez pas identifiée en tant que participante. Tous les renseignements recueillis demeureront confidentiels. Nous nous intéressons uniquement aux renseignements collectifs, c'est-à-dire les renseignements de l'ensemble des participantes, pas les renseignements d'une personne en particulier. Seuls les membres de l'équipe de recherche peuvent accéder aux renseignements recueillis, notamment Ann-Marie O'Brien, maîtrise en service social, travailleuse sociale autorisée, et la Dre Angel Foster

Les participantes recevront une carte-cadeau VISA de 50 \$ pour le temps qu'elles ont consacré au projet.

La chercheuse principale est Ann-Marie O'Brien. On peut communiquer avec elle à l'adresse [ann-marie.obrien@theroyal.ca](mailto:ann-marie.obrien@theroyal.ca) ou en composant le 613-722-6521, poste 6879.

J'ai lu et je comprends l'étude proposée, et je consens à y participer :

Nom

Date

Version du 2 juin 2018