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MENTAL HEALTH AND ADDICTIONS IN WOMEN
Mergers and Acquisitions: Making Them Work for Women

WOMEN AND GIRLS have always had sex- and gender-specific issues regarding mental health, substance use and addiction. Over the years, these issues have been largely ignored, in part because men have often been the focus of treatment and research, or because in some cases men have exhibited higher rates of these problems or greater effects as a result of having them. Recently however, several research and policy initiatives in Canada have begun to ask how women and men are affected differently by mental illness, substance use and addiction.

It is well established that certain mental illnesses are more prevalent in women, that women use mental health services more frequently than men, and that women would prefer a wider range of treatment and support options than are currently available. The needs and concerns of women with substance use problems or concurrent disorders are also often different than men's. This reflects both biological differences between women and men and the different social roles that men and women continue to occupy. For example, women's average smaller body size, higher ratio of body fat and differing mechanisms of metabolism often mean it takes less of a substance to have an effect on girls' and women's bodies. With respect to social roles, women's greater responsibility for children means that their substance use or mental health concerns are differently scrutinized by authorities than men's and carry an elevated and different level of stigma and societal concern.

Issues such as these remind us that we need to continue to push for recognition of women's specific attributes and circumstances. The release of the Canadian Addiction Survey and the work of the Standing Senate Committee on Social Affairs, Science and Technology chaired by Senator Michael Kirby create opportunities for much-needed changes in Canada. Individuals with mental health or addictions and substance use issues are often subjected to stigma,

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■ Merging mental health and addictions may turn out to be a good thing if we work to make sure that the merger acquires a perspective that reflects the complexities of women's lives.

c o n t ' d

misunderstanding and blame. Women who are pregnant or mothering are especially stigmatized if they have problems with mental health or addictions and report problems accessing help. Indeed, unwelcome or inappropriate state intervention with pregnant substance-using women has been a key issue for women's health activists in Canada. Care systems often fail to recognize either the overlaps between mental health and substance use or the instances of both that occur without the influence of the other. For women, care and treatment have often failed to integrate trauma and violence histories in responding to substance use and/or mental health problems.

This failure to "connect the dots" is difficult to reconcile with the increased merging of the mental health and addictions fields in practice, research and policy making. While useful and efficient for research and systems planning, this merger runs the risk of minimizing or obliterating the specific interests of one group of clients or care providers, who may not identify with a landscape that covers two such broad areas. For example, while the majority of patients in psychiatric facilities use tobacco and should therefore be treated for both nicotine addiction and mental illness, most tobacco users are not diagnosed with, or see themselves as having, a mental health issue.

This issue of the *Research Bulletin* focuses on all of these issues—sex, gender and women's health in relation to mental health and problematic substance use. The articles describe substance use, trauma and stress in women's lives, reflecting the higher levels of trauma and violence that contribute to both mental health and substance use problems for women. The articles also identify features of our economic and social structure in Canada that create or perpetuate mental health

difficulties such as women's unpaid caregiving and aspects of pregnancy and mothering. Carrying out these roles successfully is incongruent with many forms of substance use yet women often describe these gendered roles as stressful and their options for managing as limited.

Numerous policy questions are suggested by the work described here. How are women and men affected differently by psychiatric deinstitutionalization? How can traditional tobacco control policies be tailored to gender and diversity to further reduce tobacco use among vulnerable groups both in Canada and elsewhere? How can our national support programs better reflect the health costs of caregiver stress on women?

Merging mental health and addictions may turn out to be a good thing if we work to make sure that the merger acquires a perspective that reflects the complexities of women's lives, the multiple contributors to mental illness or addiction, and the interactivity of treatment approaches. Policies aimed at addressing either (or both) of these phenomena must be assessed for their women-friendly features. Do they improve access to care, decrease stigma, sensitively account for pregnancy, motherhood and caregiving, reflect the particular toll of trauma and interpersonal violence and contribute to ameliorating women's greater burden of poverty? It's a tall order but a clear vision.

Lorraine Greaves
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Women and Tobacco: An International Epidemic

Natasha Jategaonkar and Lorraine Greaves, British Columbia Centre of Excellence for Women's Health

Tobacco use is increasingly a global epidemic. Currently, 1.1 billion people worldwide are smokers, and this number is expected to increase to 1.6 billion by 2025.[1] Although overall rates of smoking are declining in some developed countries, including Canada, they are increasing in many developing nations, particularly among women. By 2020, 20 percent of the world's women will be smokers.[2] Given these escalating rates of cigarette smoking among women, women's susceptibility to related diseases, and the lack of knowledge about the effects of tobacco policies on girls' and women's lives, it is clear that the world is on the verge of an international epidemic of female morbidity and mortality arising from women's use of tobacco.

The British Columbia Centre of Excellence for Women's Health (BCCEWH) is engaged in several projects with Health Canada, the International Network of Women Against Tobacco (INWAT), the World Health Organization (WHO), the American Cancer Society and Cancer Research UK that examine different aspects of women's roles in the consumption and production of tobacco, the effects of tobacco use on women's health and the impact of tobacco control efforts on girls and women around the world.

How Tobacco Policies Affect Girls and Women

To date, comprehensive tobacco control policies have been widely implemented in several developed countries and are being implemented in developing countries. However, such policies have largely failed to address how and to what extent tobacco control initiatives may differentially affect girls and women, particularly those who are marginalized as a result of social and/or economic factors.

Work at the BCCEWH is currently assessing the effects of comprehensive tobacco control policies on Aboriginal women, young pregnant women, women from various ethnic communities and women of low socioeconomic status. We are also examining the links between tobacco control efforts and other public policies, including social housing and social assistance. By explicitly examining the consequences of other policies on various aspects of girls' and women's health and well-being, and by providing suggestions for developing and assessing gender-sensitive tobacco programs and policies for

vulnerable girls and women, these projects will enhance policy mechanisms to reduce women's tobacco use.

To date, the majority of studies investigating the effects of tobacco control policy have studied the general population, with few considering gender-specific effects. Nonetheless, we can sometimes extract results that reflect the differential impact of tobacco control policy on diverse subgroups of girls and women. For example, literature on sales restrictions indicates that girls are less likely to attempt to purchase cigarettes,[3] but are more likely than boys to acquire cigarettes from non-commercial sources.[4] In the US, Latino teenagers are more likely to successfully purchase cigarettes than White teenagers, and Latina girls are more likely to be successful than Latino boys.[5]

In examining gender differences in responsiveness to tobacco tax increases, we noted divergent results. Farrelly and colleagues report that women in the US are more price-responsive than men.[6] Borren and Sutton also report greater price responsiveness among women in a UK sample but Stephens and others find equal price responsiveness among women and men in Canada.[7]

Evidence regarding gender differences in the impact of smoking location restrictions is limited. Gritz and colleagues carried out a study to evaluate the impact of a workplace intervention and report that, as a result of the intervention, women were more likely than men to report smoking fewer cigarettes per day but they also report fewer attempts at quitting.[8] There was no difference observed in the proportion of women and men who were able to successfully quit smoking.

Putting Lung Disease on the Global Women's Health Agenda

Lung health remains an under-recognized issue within the global women's health movement. The worldwide epidemic of tobacco use among women has shaped current understandings of female lung disease. That is, tobacco use from either direct or passive smoking is usually identified as the primary or most significant contributor to lung disease among women. However, occupational exposure to pollutants and the use of biomass fuel for cooking are also major causes of lung disease, particularly for women in developing countries.

Researchers from the BCCEWH, the University of British Columbia and St. Paul's Hospital in Vancouver have developed a collaborative, interdisciplinary program of research that specifically examines issues of gender and chronic obstructive pulmonary disease (COPD). This group, Interdisciplinary Capacity Enhancement: Bridging Excellence in Respiratory Disease and Gender Studies or ICEBERGS (funded by the Canadian Institutes of Health Research), aims to raise the level of awareness of gender-related aspects of COPD and to improve the diagnosis and treatment of women with this disease and with respiratory illness in general. A series of projects is currently underway, including one examining the lung-health effects of biomass fuels among women in Mexico and another examining lung-health policies and programs worldwide for their gender- and diversity-sensitivity.

How Can We Arrest the Spread of Tobacco Use Among the World's Women?

All of these issues, and more, will be addressed in a forthcoming report called "Responding to the Global Tobacco Epidemic among Women" to be prepared by the British Columbia Centre of Excellence for Women's Health in partnership with the International Network of Women Against Tobacco (INWAT).[9] The publication will provide an overview of worldwide trends in women's tobacco use, including the social context in which they occur; current information on tobacco's adverse effects on women's health throughout the life cycle; a snapshot of women's roles in the cultivation, manufacturing and marketing of tobacco as well as a commentary on how international human rights treaties (such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, the UN Convention on the Rights of the Child (CRC), adopted in 1989, and the WHO Framework Convention on Tobacco Control (FCTC)) can advance progress in tobacco control. The report, to be launched at the World Conference on Tobacco or Health in Washington, DC in July 2006, will conclude with a resource chapter on how to apply gender-based diversity analysis to tobacco policy and program development within countries at different stages of the tobacco epidemic.

A second analysis, conducted by the BCCEWH for the World Health Organization addresses opportunities for integrating awareness of gender and diversity into the enactment of the WHO Framework Convention on Tobacco Control (FCTC), which is the first international public health treaty in the world. This report will be released in 2006 by the WHO and will be used by its member states to assist with introducing considerations of sex, gender and diversity into surveillance, policy making and program development in tobacco control in all regions of the world.

The British Columbia Centre of Excellence for Women's Health has a strong, dedicated unit devoted to research, policy development, better practices and clinical improvements in responding to girls, women, gender and tobacco. We are committed to continued partnerships with tobacco control and women's health advocates around the world with the goal of foreshortening the progression of this global epidemic.

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Dangerous Prescriptions? Benzodiazepine Use among Aboriginal Senior Women

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Researchers are increasingly documenting the ways that lifelong, gender-related social and health inequalities can create and perpetuate mental health difficulties for Aboriginal senior women. One long-standing example is the over-prescription of benzodiazepines to older Aboriginal women. Intended to treat problems with sleep, anxiety and related conditions, benzodiazepines are often prescribed inappropriately to women coping with difficult life circumstances such as stress from work or home life, caregiving responsibilities, grief, acute or chronic illness, physical pain or adjustment to a major life change.[1] For Aboriginal women, these problems are compounded by the legacy of colonization which is today associated for older Aboriginal women with higher rates of poverty, violence, single parenting, widowhood and disability.[2]

When women seek help from physicians for feelings of anxiety, depression or insomnia connected to their life experiences, the result is often a prescription for benzodiazepines. The correlation between histories of trauma and abuse and diagnoses of Post Traumatic Stress Disorder (PTSD)—the mental health problem most frequently diagnosed among residential school survivors—can also place Aboriginal seniors at risk for benzodiazepine use because PTSD is often "treated" with benzodiazepines.[3] PTSD is also found among survivors of battering and sexual violence, which Aboriginal women experience at three times the rate of non-Aboriginal women and men.[4] Lack of culturally responsive health services may put Aboriginal women at increased risk for inappropriate prescription of benzodiazepines. For example, most existing mental health assessment tools are not culturally informed and/or do not lend themselves to the accurate assessment of Aboriginal seniors' mental health status.[5] To make matters worse, non-Aboriginal health care professionals may misinterpret behaviours exhibited by older Aboriginal women, leading to misdiagnosis of psychopathology and both under- and over-treatment of suspected mental "illness."[6]

Benzodiazepines are central nervous system depressants and they have been shown to have significant side effects, including over-sedation, memory and learning impairment, depression, emotional blunting, and paradoxical aggression. They are also highly addictive. Given these characteristics,

■ Lack of culturally responsive health services may put Aboriginal women at increased risk for inappropriate prescription of benzodiazepines.

■ The gender gap in benzodiazepine prescriptions may be even wider in Aboriginal populations.

benzodiazepines are meant for short-term use of no more than four weeks.[7]

However, one in ten Canadians report using a benzodiazepine at least once each year and continue using them for at least a year.[8] Women and older adults are the two groups most likely to be prescribed benzodiazepines, and are also the most vulnerable to adverse effects.[9] Studies show that women are twice as likely as men to have benzodiazepines prescribed to them.[10] Although we do not know how Aboriginal peoples' use of benzodiazepines compares to non-Aboriginal people's use of these drugs, it appears that the gender gap in benzodiazepine prescriptions may be even wider in Aboriginal populations. A recent study of benzodiazepine use among registered First Nations residents of western provinces found that women accounted for almost two thirds of benzodiazepine prescriptions.[11] The average number of prescriptions received by clients was 7.7 per year, well beyond low-risk thresholds.[12] Due to the serious health implications of long-term benzodiazepine use, these numbers warrant attention.

Benzos and Fall-related Injuries

Benzodiazepines have a well-established link to fall-related injuries among seniors.[13] This is because benzodiazepines can impair memory, cognition and balance even when prescribed at low-risk thresholds. A recent study of fracture risk among First Nations people found significantly higher rates of any fracture compared to non-Aboriginal people.[14] When all fracture types were considered, there was a strong pattern of increasing risk with advancing age among First Nations women. This suggests that older Aboriginal women may be at particular risk for injury given their vulnerability to fractures in general, in combination with the risk associated with falls while using benzodiazepines.

Overdoses

Benzodiazepines are also the most commonly implicated substances in drug overdoses,[15] which occur most often when benzodiazepines are taken in combination with other drugs, such as alcohol. Although it is not known whether Aboriginal populations exhibit higher rates of alcohol use than non-Aboriginal populations in Canada, problematic alcohol use has been identified repeatedly by Aboriginal women and community leaders as a major concern.[16] Canadian statistics indicate that anywhere from 30 to 75 percent of people who have problems with alcohol also use benzodiazepines regularly.[17] These interactions can be fatal.

The Challenges of Withdrawal

When women want to stop using benzodiazepines, they often find that withdrawal is poorly managed, if it is managed at all.[18] Withdrawal from benzodiazepines should be tapered gradually to avoid convulsions, acute anxiety, panic attacks and other symptoms that can occur with abrupt withdrawal. This process requires trained professionals and dedicated out-patient benzodiazepine clinics, since other drug-detoxification units are not suitable.[19] For Aboriginal seniors, the risks accompanying benzodiazepine withdrawal can be compounded by a lack of appropriate community mental health services, particularly those designed to respond to immediate and acute mental health concerns of those affected by the residential school system and those living in rural and remote areas.[20]

Researchers at the British Columbia Centre of Excellence for Women's Health have recently completed two reports that provide insight into the prescription of benzodiazepines to relieve anxiety and related conditions among older First Nations and Inuit women and men.[21] These reports conclude that more research is urgently needed to effectively confront this emerging health crisis and suggest that the key to preventing the over-utilization and prescription of benzodiazepines lies in addressing the inequalities that are determinants of older Aboriginal women's mental health and the implementation of comprehensive, community-based mental health programs.

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Social Determinants of Mental Health Disparities among New Mothers

Cecilia Benoit, Rachel Westfall, Adrienne Bonfonti and Kim Nuernberger, Department of Sociology, University of Victoria, and the National Network on Environments and Women's Health

Research into the social determinants of health has shone new light upon disparities in health outcomes and their relation to a broad range of social factors including, but certainly not limited to, social support in early childhood, economic stability, educational achievement, housing and food security, and access to affordable and adequate health and social care.[1] Although many studies have explored the clinical causes of maternal morbidity and in particular postpartum depression, there has been little research on the social determinants of mental health disparities among new mothers, with the exception of a few studies on the relationship between type of delivery—vaginal birth versus caesarean section[2]—and critical life stresses and postpartum depression.[3] Although popular celebrity biographies have recently brought postpartum depression to public attention,[4] far less attention has been paid to the fundamental causes of mental health disparities among different groups of new mothers.

To begin to examine the wide range in postpartum mental health, researchers at the University of Victoria have begun to explore why some new mothers fare better than others in terms of mental well-being. We are conducting a longitudinal study of a diverse sample of pregnant women residing in the Greater Metropolitan Area of Victoria.[5] Each woman is being personally interviewed once during the final trimester of pregnancy, again four to six weeks after the birth, and a third time four to six months postpartum. Using a mixed-methods design, we are collecting both quantitative and qualitative data on the women's socio-economic backgrounds, early childhood circumstances and other social determinants of health, as well as their use of and satisfaction with different types of maternity care, experiences of birth and motherhood, sources of social and financial support and self-reported health. Participants were recruited to the project through fliers distributed at Victoria ultrasound clinics and in midwife and physician offices. To date, participant recruitment is complete, with 100 participants

recruited and 93 interviews completed for wave one, 60 for wave two, and 27 for wave three. We anticipate the project will be completed by June 2007. Data on 81 interviews have been entered into the Statistical Package for the Social Sciences and form the basis for the preliminary analysis presented here. Because data collection is still ongoing and sample sizes in some categories are currently small, these interpretations should be approached with caution.

Women's Self-reported Mental Health

During the first wave of interviews, women were asked to self-rate their physical and mental (and emotional) health using a five-point Likert scale ranging from excellent to poor. Women consistently rated their physical health higher than their mental health, with 59 percent of participants indicating that their physical health was excellent or very good, while 51 percent reported that they would rate their mental health in these same categories. Conversely, 16 percent of participants reported fair or poor physical health, whereas 26 percent reported fair or poor mental health. For the purposes of this study, we are interested in social factors related to mental health only.

The sample is relatively balanced between women selecting midwifery care (36 participants) and women seeing a physician (45 participants) for prenatal care. Participants using the services of a midwife were only slightly more likely to provide positive responses when asked about their self-rated mental health than those who were receiving care from a physician (either an obstetrician or a family or general practice physician).

The different ratings are not significant enough to draw connections between the type of maternity care provider and women's self-reported mental health status during pregnancy. We therefore thought it important to investigate what other factors might be related to mental health disparities within this group of women.

■ **Although popular celebrity biographies have recently brought postpartum depression to public attention, far less attention has been paid to the fundamental causes of mental health disparities among different groups of new mothers.**

Social Factors in New Mothers' Mental Health

A measure of early childhood stability included in this study was the number of times the study participant moved before the age of 18. From the initial data, there appears to be a correlation between those who moved more than ten times before their eighteenth birthday and a decreased likelihood of rating their mental health as excellent or very good and an increased likelihood of rating their mental health as either fair or poor (see Table 1). Parallels between early childhood stability and adult health status have frequently been drawn and, as the 1999 Health Canada report *Toward a Healthy Future* indicates, early childhood experiences have an effect on stress levels in young people and tend to reduce their resistance to health-related problems in later life.[6]

Another significant social determinant of health is educational attainment, which is undeniably linked to many other social determinants of health including socioeconomic status, employment security, and access to and use of health care services.[7] Preliminary analysis of our data indicates that participants with a higher level of completed formal education were more likely to report excellent or very good mental health, while those with no post-secondary education were more likely to report fair or poor mental health. The differences were slight, so a larger sample is needed to determine whether these differences are significant.

Housing status is also often cited as an important social determinant of health, in particular as it relates to housing stability and security.[8] The data from the first wave of this study suggest that increased housing security is linked to better health and well-being. Participants who owned their own home or apartment (an indication of a greater sense of housing stability and security) were more likely to self-report higher mental health status. Those whose living situation involved renting subsidized housing faired much worse, with 86 percent of all participants in this category reporting either fair or poor mental health status. It is worth noting that the mental health status

Number of times moved before age 18	Excellent & Very good	Good	Fair & Poor	Percent
None	58%	33%	8%	15%
1-3 times	53%	20%	27%	37%
4-9 times	62%	29%	10%	26%
10 or more times	38%	19%	44%	20%
Missing				2%
Total				100%

Table 1: Women's self-rated mental health by early childhood stability

Table 2: Women's self-rated mental health by housing status

Current housing	Excellent & Very good	Good	Fair & Poor	Percent
Own house or apartment	56%	22%	22%	40%
Rent house or apartment	51%	34%	14%	43%
Rent subsidized housing	14%	0%	86%	9%
Transitional housing	50%	17%	33%	7%
Missing				1%
Total	50%	25%	25%	100%

Note: Transitional housing includes temporary living situations and shelters.

among the women living in a transitional housing situation was considerably different from what one would expect, given that this group has the lowest level of housing security (see Table 2). However, the sample size is quite small and it is difficult to state with any level of certainty why this is the case. The open-ended data indicate that some of these women were living with parents or friends as they prepared to move to a larger space to accommodate the new baby.

Summary

Based on only a small proportion of the overall data being collected for this study, a preliminary analysis of social factors that affect new mothers' mental health indicates that women who have midwives as maternity care givers are somewhat more likely to report higher rates of mental health than those receiving care from physicians. Further, mental well-being is also correlated with early childhood stability, educational attainment, and current housing security. Future analyses will confirm whether these preliminary findings continue to have a significant impact on mental health and identify additional social factors that negatively affect new mothers' mental well-being in the short and long term.

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UNDERSTANDING MENTAL HEALTH AND ADDICTIONS FOR WOMEN

Women's Unpaid Caregiving and Stress

Cyndi Brannen, Healthy Balance Research Program

If the title of this article makes you wonder if your daughter has enough medication to last until payday or whether your father-in-law's new home-care worker will actually follow your instructions, then you are like many women in Canada today. It's no secret that women provide the vast majority of care for family and friends,[1] but the health effects of women's unpaid caregiving have not been well researched.

What little research there is on stress and caregiving typically focuses on the mental health of individuals providing care for others with a specific disease or problem. For example, one-third of women caregivers for individuals with Multiple Sclerosis are distressed to the point that they have a clinical disorder themselves.[2] A landmark study on the connections between caring for an individual with Alzheimer's disease and depression in caregivers reported that over 50 percent of female caregivers suffered from clinical depression.[3] Numerous studies have reported that more women than men are likely to suffer negative health effects of caregiving, especially in regards to mental health.[4] One explanation for these findings is that because caregiving is central to most women's identities, it is more likely to lead to distress for women than for men.[5] Another possible explanation is that not only do women shoulder the burden for the vast majority of caregiving but they are also more likely to be responsible for tasks that are stressful. Men are more likely to be involved in instrumental caregiving, such as household repairs, while women are more apt to be responsible for medical appointments and providing emotional support to the care recipient, activities which engage the caregiver themselves in emotional ways that may be stressful.[6]

The Healthy Balance Research Program (HBRP) in Nova Scotia has extensively studied the causes underlying women's disproportionate share of caregiving responsibilities and the accompanying negative health effects, especially the experience of negative stress. The HBRP was developed to investigate women's unpaid caregiving across a range of settings, from taking care of children to providing care for aging parents within Nova Scotia. Based on the results of two projects of the HBRP, it appears that Nova Scotian women experience many negative outcomes in association with their unpaid caregiving. Measuring stress is one way to evaluate the overall negative health impact of caregiving, especially because stress has been linked to a whole variety of negative health effects.

Using quantitative and qualitative methods, HBRP researchers have documented that caregiving is very stressful for many women. For example, HBRP researchers Martha MacDonald, Shelley Phipps and Lynn Lethbridge report that women are more likely to provide care and to experience stress as a result of trying to balance their work and home responsibilities.[7] MacDonald and colleagues analyzed data on Nova Scotian women from the Canadian census and the

■ **Women, regardless of the number of hours of paid work they do outside the home, still report more hours of unpaid caregiving in the home than their male partners.**

General Social Survey. They found that women, regardless of the number of hours of paid work they do outside the home, still report more hours of unpaid caregiving in the home than their male partners. They also found that women in the "sandwich" generation—those providing care for both children and aging family members—may experience more stress than any other group of caregivers. MacDonald and colleagues found that for men there is no association between stress and hours of unpaid caregiving, but that for women increased caregiving hours lead to increases in stress.[8]

Focus groups conducted as part of the HBRP gave women a forum to discuss the health effects of their caregiving.[9] These focus groups consisted of women involved in many types of caregiving from diverse backgrounds. Across caregiving types, ethnic groups and geographic location, many women reported that caregiving led to feelings of depression and helplessness. These women also discussed poor eating habits and disturbed sleep.

A few women in the focus groups described positive aspects of caregiving. They discussed how being a caregiver made them feel good about themselves and the skills they had acquired as a result of caregiving. What was interesting is that women who reported positive experiences of caregiving did not have a "lighter" caregiving load than depressed and stressed women, but for a variety of reasons—some of them still unclear—they were better able to cope with their load and not feel depressed. An analysis of the coping mechanisms used to offset caregiving-related stress indicated that these "unstressed" women could cope in a way that was appropriate to the problems they faced.[10] For example, they drew on strong personal and community support networks and knowledge of programs and services available to care recipients. Women in the focus groups who did not experience caregiving as stressful also mentioned that they believed they had had a right to support and services. If caregivers can approach caregiving this way, it may help to reduce stress.

Nova Scotia's Healthy Balance Research Program has contributed to the growing body of research that demonstrates the need for policies and programs that address the negative health consequences of caregiving and that recognize that the burden of caregiving falls disproportionately on the shoulders of women. As the HRBP moves into its final phase, our research findings and policy analysis can contribute to the growing national discussion on caregiving.

For more information about the Healthy Balance Research Program, see www.healthyb.dal.ca

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Women, Girls and Substance Use: Some of the Facts

Alcohol is the most common substance used by women in Canada, and its use has been on the rise over the past decade. Younger women drink more than older women, but income and education influence these patterns as women age. While women's safe-drinking limit is four drinks per sitting, over 40 percent of 18 to 19 year olds drink more than that. Compared to men, women suffer more relationship violence and other problems in addition to their own and others' alcohol use. Because there is no safe level of use, tobacco remains the most damaging drug for women but many women and girls still smoke. While rates of smoking are decreasing among women overall, poor women, single mothers and Aboriginal girls and women are more likely to smoke.

Cannabis is increasingly popular among young Canadian women; its use has increased threefold in the last 15 years. Women with mental health disorders sometimes self-medicate with cannabis and/or tobacco. Although twice as many women as men use cannabis to alleviate depression (according to the Canadian Addiction Survey), other illicit drugs are much less popular among women. Only 12 percent of Canadian women have used an illicit drug (excluding cannabis) in their lifetime. Among the illicit drugs used by women, the most common drugs are cocaine (7.1%) and hallucinogens (7.1%), followed by speed and ecstasy (4.1% and 3.0% respectively). Most illicit drug use begins in the late teen years among women, with usage peaking in the mid-twenties.

The British Columbia Centre of Excellence for Women's Health and the Canadian Centre on Substance Abuse (CCSA) have a formal partnership aimed at creating resources designed to influence policy, research and practice on women and substance use. A recent joint publication on the topic is entitled "Girls, Women and Substance Use," and can be downloaded from the CCSA website at www.ccsa.ca. (Follow the links from "topics" to "populations" and then find the report under "women.")

RESPONDING TO MENTAL HEALTH AND ADDICTIONS IN WOMEN

Fostering Social Support for Women Living with Serious Mental Illness

Wanda M. Chernomas, University of Manitoba and Diana E. Clarke, University of Manitoba and Health Sciences Centre, Winnipeg

The people in a social support network can help someone find solutions to problems, validate an individual's identity, direct the individual to helpful information, and provide comfort when that is all that can be done. Because connections to others contribute to a sense of well-being and give meaning to life, social support has been identified as one of the determinants of health. For people living with schizophrenia, it is a painful irony that a vital support system is placed at risk by the very illness that needs the support of relationships.

Schizophrenia can cause disorganized thinking, hallucinations and delusions. It can cause depression, lack of motivation and can inhibit a person's ability to make meaningful connections with others. Like most mental illnesses, schizophrenia is a condition that is also highly stigmatized. Thus, over time, developing and maintaining relationships can be difficult for people with the condition.

In a 2000 study, "The Perspectives of Women Living with Schizophrenia," Chernomas, Clarke and Chisholm found that women with schizophrenia expressed the need for more people in their lives, particularly friendships.[1] The current study, "Social Support and Women Living with Serious Mental Illness," builds on that earlier research with an in-depth exploration of the formal and informal sources of support for women with schizophrenia. In personal interviews, 14 Manitoba women

living in the community who self-identified as being diagnosed with schizophrenia talked about support in the context of their everyday lives, their responsibilities, and their sense of self in light of having a serious mental illness. The women were asked about their experiences in negotiating support from both formal and informal resources, barriers to finding and accessing social support, and their perceptions of the links between social support and the ability to manage their lives. The research was supported by the Prairie Women's Health Centre of Excellence.

Most of the women were unemployed, lived in poverty, and relied on social assistance. Two thirds reported incomes of less than $10,000 annually. Some lived with physical health problems as well their mental illness. Most women had few responsibilities or activities to occupy their days, outside of limited social contacts and some structured activities. They relied on public transportation to get to appointments or other activities. The telephone was an important medium to connect them with members of their support system, especially in times of crisis.

The women identified family members and mental health care providers as the most socially supportive people in their lives. These people provided a wide range of both practical and emotional supports. Although women friends were largely confined to those who also lived with serious mental illness, these friends were identified as providing meaningful sources of connection. In contrast to family members and health care providers, friends offered largely affective support. Significantly, the women in the study conveyed a sense of reciprocity as they talked about these relationships and their place within the community as women with a serious mental illness.

Although living with a serious mental illness and the social context of these women's lives made establishing and maintaining social support systems difficult, this study suggests that such connections are important for women with schizophrenia. Policy makers, health care providers and program planners could improve the lives of women living with serious mental illness through actions that help foster their social support systems.

The findings from this study reinforce those cited in other discussions promoting gender-sensitive health policies and a women-centred, primary health care approach for women with serious mental illness.[2] Developing innovative ways to facilitate the implementation of these recommendations would support women with serious mental illness during recovery and re-integration into their communities.

Recommendations

1. Provide support for community-based services, activities, and supports, specifically for women with serious mental illnesses.

2. Provide education and support for women with serious mental illness who support each other.

3. Provide education to family members about the role of social support in the lives of women with schizophrenia; family members also need support.

4. Provide women with serious mental illness with access to a health care worker who is knowledgeable about available resources and can assist women in making choices about suitable resources in the community.

5. Improve intersectoral partnerships among agencies serving women in general and women with serious mental illness in particular.

6. Increase access to female health care providers to discuss sensitive health care issues.

7. Support telephone services as part of social assistance.

8. Provide support for a bus pass as part of social assistance.

9. Enhance opportunities for women with serious mental illness to participate in vocational training programs.

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Connecting Systems, Supporting Change: Transition Houses, Women Experiencing Partner Violence and Substance Use

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Researchers report high rates of intimate partner violence among women who use substances.[1] However, few studies have investigated the use of alcohol and other substances by women who have left violent partners to reside in shelters/transition houses. However, for substance-using women experiencing intimate partner violence, entering a shelter can be a key life transition and an opportunity to confront many personal difficulties. For shelter staff, this situation offers an important opportunity to influence women's problematic substance use and to assist them to manage any related stresses underlying their substance use. A recent study explored the relationship between the use of alcohol and other substances, the levels of reported stress in substance-using women who experience intimate partner violence and the impact of alcohol and substance use interventions made available in transition houses or shelters.[2]

Study Design

Every woman who entered any of the 13 transition houses in British Columbia between October 2002 and June 2003 was invited to participate in the study. Women who completed screening and consent forms were eligible for the study if they identified using alcohol or any substance more than five times a week (unless the only substance used was nicotine). Women were also eligible to participate in the study if they identified the use of multiple substances (from once a month to more than five times a week) or if they self-reported a current problem with alcohol or any of the other substances.

Women who indicated these levels of substance use at the time of seeking refuge were interviewed twice, first near the time of entering the transition house (Time 1) and again approximately three months later when they were living in the community (Time 2). Each interview included questionnaires regarding the woman's use of alcohol and other substances, stress levels, and experience of intimate partner violence (Brief Michigan Alcohol Screening Test,[3] Drinking Motives Questionnaire,[4] Timeline Follow-back calendar,[5] Index of Spouse Abuse,[6] Perceived Stress Scale-10[7] and a non-standardized Stressors Questionnaire). The interview also included open-ended questions designed to gather information in the women's own words. Seventy-four women completed both interviews.

Findings

Substance Use

Although the percentage of women using tobacco remained relatively constant, women significantly reduced their use of alcohol from Time 1 to Time 2. Other than alcohol and tobacco, stimulants were the most commonly used category of drugs used at Time 1. As with alcohol, there was a significant reduction in the frequency of stimulant use observed at Time 2.

■ **For substance-using women experiencing intimate partner violence, entering a shelter can be a key life transition and an opportunity to confront many personal difficulties.**

Table 1. Frequency of alcohol and other substance use at Time 1 and Time 2

	TIME 1	TIME 2
Drug Category	**Mean number of days using >3 drinks**	**Mean number of days using >3 drinks**
Alcohol[a]	**15.75**	**4.42**
	Percent current smokers	**Percent current smokers**
Tobacco	**77%**	**73%**
	Mean percent (%) of days of use	**Mean percent (%) of days of use**
Stimulants[b]	**20.19%**	**3.95%**
Depressants (non-medical use)[c]	**18.76%**	**12.66%**
Depressants (medical use)[d]	**17.72%**	**15.22%**

[a] Alcohol use is described by the number of days within the previous three months a woman had consumed three or more alcoholic drinks on a single occasion (i.e., "binge drinking").
[b] Cocaine and methamphetamine are key examples of stimulants used.
[c] Cannabis, heroin, as well as prescription painkillers and tranquillizers used in a non-prescribed way.
[d] Depressants used in a prescribed fashion (regular frequency and consistent, appropriate quantities) – benzodiazepines were the most common depressants used medically.

However, use of depressants, either medical or non-medical, did not show a significant decrease from Time 1 to Time 2.

We compared alcohol and other substance use among women who accessed help from transition houses with both significant and minimal substance use interventions. Interestingly, women who received either level of intervention reduced their use of alcohol and other substances.

Stress Levels

Women reported less stress in many areas of their lives after their stay in a transition house. The most significant change was observed in stress due to relationships with a partner, followed by mental health, legal issues, housing, and physical health. As Figure 1 shows, large decreases in reported stress were observed but these factors nevertheless remain major sources of stress in the women's lives at Time 2.

Figure 1. Women experiencing "great stress" due to factors in their lives
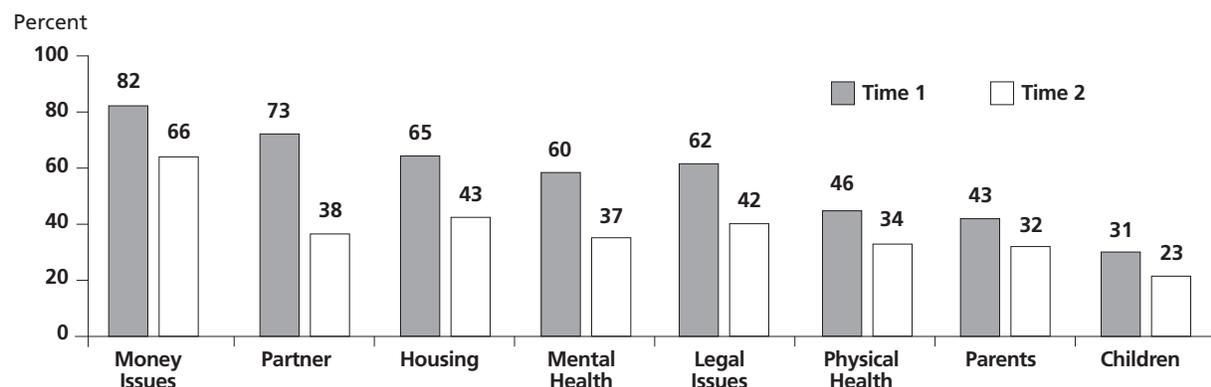
Women's descriptions of their experience of substance use, stressors (whether psychosocial, relational, or structural) and violence illuminated a complex relationship between violence and the use of substances. Structural issues such as housing, income assistance, transportation, and access to health care were integrally related to women's stress and substance use, and fragmented health and social services were a common barrier to women's efforts to improve their lives. Participants indicated that they had difficulties navigating the health and social services systems because these systems and services are not coordinated to deal with multiple issues. This was particularly true for rural women who were more likely than urban women to have difficulties accessing services.

Conclusions and Recommendations

This study identified transition houses as playing a positive role in supporting multidimensional change in women's lives; the women reported significant improvements in both stress and substance use following their shelter experience. This study suggests it is therefore important to increase awareness of the interconnections between substance use, mental health, experiences of violence and the need for income/social service supports. There is also a need to create an integrated service infrastructure that supports women to sustain changes and rebuild their lives in the period following a stay in transition house.

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Relocations, Dislocations and Innovations in Mental Health Reform: Examining the Impact of Psychiatric Deinstitutionalization on Women, Men and Communities

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Over the past three decades, developments in the understanding and treatment of mental health problems and broader social and economic trends have shaped the restructuring of the Canadian health care system. A key feature of mental health reform has been the deinstitutionalization of people with serious forms of mental illness from large psychiatric hospitals to various kinds of facilities, including more home-like tertiary care facilities and other forms of supported housing in the community.

In British Columbia, the most recent phase of deinstitutionalization began in 2000 and has involved both the restructuring of the province's only tertiary psychiatric facility, Riverview Hospital, and the transfer of people from the Lower Mainland to different facilities throughout the province. In BC's regionalized health care delivery system, in which resources are following individuals from a large urban centre to smaller communities, this phase of deinstitutionalization is likely to place new demands on mental health services in these communities, provide increased job opportunities in the mental health sector and generate greater interaction between community residents and people diagnosed with serious mental illnesses. Despite these changes and pressures it is expected that new models of residential care will enhance quality of life for people with serious psychiatric problems. To date, however, little is known about the ways in which deinstitutionalization might affect men and women differently and what kind of unique needs arise when people are relocated to new communities.[1]

Traditionally, it was assumed that the later onset of mental illness in women, better pre-morbid functioning, shorter hospital stays during periods of illness and wider networks of social support favoured women's residential independence,[2] as did women's greater skills for maintaining a household and fulfilling family roles.[3] However, although initially mentally ill women often do better than men in independent living situations, research suggests that these benefits are not necessarily sustained over time.[4] Research also shows that social variables play an important role in mental illness, most notably the fact that mental illness is exacerbated by lack of income security and social support.[5]

The Challenges of Fitting In

Divergent viewpoints about the causes and treatment of mental illness, combined with stigmatizing misperceptions about mental illness, may threaten the ability of new people to integrate into towns where populations are small and traditions of acceptable social behaviour are entrenched.[6] A recent study from Australia found that even six years after deinstitutionalization, issues of social integration remain.[7] Other studies have also demonstrated the need for sustained strategies for public education and opportunities for integration.[8] In fact, among deinstitutionalized residents, the attitudes of the community towards them and towards mental illness in general have been identified as priority problems.[9]

The deinstitutionalization of people with mental illness raises a myriad of other integration issues, including increased stresses on community-based organizations and voluntary caregiving labour that is often provided by female family members. Consumer advocacy organizations also feel stress when care is transferred to communities because mental health service recipients often require complex forms of advocacy when they live in communities. In addition, appropriate housing is probably the crucial community support service needed to achieve success of community-based care for people with mental illness.[10] A recent study using grounded theory demonstrates the interaction between the quality of housing for persons with mental illness and the quality of their relationships, which in turn relates to the level of social support they experience.[11] Although various studies have begun to

demonstrate improvements for people with mental illness through the process of deinstitutionalization, all have found that it is contingent on the provision of a broad range of adequate resources.[12]

If deinstitutionalization is to be successful, the full range of people involved has to be engaged in it, especially people diagnosed with mental illness. Thus, mechanisms are needed to promote community involvement and the meaningful participation of the individuals being transferred from Riverview Hospital. Documenting the myriad views and experiences of people involved with deinstitutionalization and recognizing their differing degrees of personal and institutionalized power is thus critical to building community capacity in the reform process.[13]

There are few studies investigating the outcomes of deinstitutionalization in the Canadian context and those that have been conducted focus mainly on its clinical and/or professional and bureaucratic dimensions. This study is unique in its attention to the range of people involved in deinstitutionalization (mental health care providers, recipients, family members, and community members) to the institutional relations that shape mental health reform, its gender-based analysis, and its focus on the impact of deinstitutionalization on women and men with mental illness and the communities in which they live.

NOTES

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Doing It All: Developing Integrated Support for Women Experiencing Mental Health, Trauma-related and Substance Use Problems

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The need for integrated and women-centred approaches to treatment and support for women who experience mental health, trauma-related and substance use problems is finally gaining attention. The overlap in the experience of these problems in women is significant. As many as two thirds of women with substance misuse problems report a concurrent mental health problem (e.g., PTSD, anxiety, depression)[1] and they also commonly report surviving physical and sexual abuse either as children or adults.[2] In collaboration with researchers and women experiencing these problems, women's service providers provincially (in BC), nationally and internationally have developed and piloted a range of programming that provides concurrent support on trauma-related, mental health and substance use problems. A key influence on this work has been programming developed in the United States and studied in a large cross-site study entitled the "Women, Co-occuring Disorders and Violence Study," sponsored by the US Substance Abuse and Mental Health Services Administration on the system-wide approach taken in thirteen American sites.[3]

On 1 June 2005, the BC Centre of Excellence for Women's Health sponsored a one-day session called "Doing It All" that involved nine women-serving agencies in BC who have delivered or are delivering such integrated programming, in discussing their approaches to this work, both among themselves and in a public forum.[4] Among the participants in the public forum:

- Jane Templeman of Haven Society and Carol Savage from the Vancouver Island Health Authority in Nanaimo shared information on the four-agency Willow WAI partnership and the trauma-specific services they have developed to meet the needs of women at the intersection of homelessness, sex trade work, addictions and violence. See www.havensociety.com/programs.html

- Linda Jennings of the Victoria Women's Sexual Assault Centre in Victoria discussed working with the realities of somatic symptoms and VWSAC's delivery of an adaptation of the Seeking Safety model, offered in collaboration with addictions counsellors from the Vancouver Island Health Authority and five community-based, women-serving agencies. See www.vwsac.com/agm/ag09^006.jpg

- Kathleen Whipp with Battered Women's Support Services in Vancouver described several levels of trauma-related

■ **As many as two thirds of women with substance misuse problems report a concurrent mental health problem (e.g., PTSD, anxiety, depression) and they also commonly report surviving physical and sexual abuse either as children or adults.**

groups being developed and offered at BWSS, using both the Trauma Recovery and Empowerment Model (TREM) and Seeking Safety models. See www.bwss.org/

- Kathy Oxner and Fiona Jeyachandran of the Pacifica Treatment Centre in Vancouver talked about the impact of the "Continuing the Journey" groups they have been offering in an aftercare context at this addictions treatment centre over the past two years. See www.pacificatreatment.ca/programs.html#

All of the participating organizations identified challenges in providing sustainable, visible, integrated support to women on these three issues. Because it requires sensitive discussion of the issues and of women's readiness on the part of many agencies working with women, recruitment to integrated groups on trauma and use problems is challenging. Preparing women for involvement in these groups has been addressed in a number of ways by the participating organizations, including offering introductory sessions on coping skills. In general, group facilitators seek a balance among cognitive, emotional, relational and physical healing needs that effectively supports women experiencing substance use and post-traumatic stress disorder, and they find it useful to collectively discuss their approaches. It has also been tricky to reach and build community among women who have varying goals and who are in varying stages related to substance use, healing from trauma, housing stability, etc. Finally, even with the support of positive evaluations, the lack of stable funding for these groups and initiatives poses a very significant barrier to the continuation and expansion of this work.

Integrated support on violence/trauma, mental health and substance use problems will be one focus of an upcoming national knowledge translation project sponsored by the British Columbia Centre of Excellence for Women's Health. It is entitled "Coalescing on Women's Substance Use Issues—Linking Research, Practice, and Policy," and is recently funded by the Canada Drug Strategy Community Initiatives Fund. Such integrated approaches will be one of six topics examined in virtual learning communities on key issues related to women's substance use in Canada. BCCEWH researchers will organize and synthesize research and evidence on these topics, and will engage participants from across Canada in virtual collaborative learning forums that generate summaries of key issues, resources, programs and policy. Webcasting and other virtual and print options will be utilized to widely disseminate findings on "best practice and policy" to researchers, service providers, planners, policy makers and others interested in women and substance use issues across the country. This project will be undertaken in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Canadian Women's Health Network (CWHN).

For more information on this project, contact npoole@cw.bc.ca

NOTES

1. Zilberman ML, Tavares H, Blume SB, el-Guebaly N. Substance use disorders: Sex differences and psychiatric comorbidities. *Canadian Journal of Psychiatry* 2003;48(1):5-13.

2. Ouimette PC, Kimerling R, Shaw J, Moos RH. Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly* 2000;18(3):7-17. Poole N. Aurora Centre—Annual Newsletter on 2002 Activities and Evaluation Results. Vancouver: Aurora Centre, BC Women's Hospital, 2003.

3. See www.mentalhealth.samhsa.gov/cmhs/womenandtrauma/wcdvs.asp.

4. Aurora Centre, Battered Women's Support Services, British Columbia Centre of Excellence for Women's Health, Haven Society, Pacifica Treatment Centre, Surrey Women's Centre, Vancouver Daytox, Vancouver Island Health Authority, Victoria Women's Sexual Assault Centre.