Positive Mental Health Outcomes For Women Experiencing Violence and Abuse In Rural and Remote Areas

Atlantic Centre of Excellence for Women's Health

Rural Research Centre

Transition House Association of Nova Scotia

April, 2011

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Funding for this literature review has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Positive Mental Health Outcomes for Women Experiencing Violence and Abuse in Rural and Remote Areas[1]

Introduction

Mental health is very often a contributing factor for women who experience intimate partner violence. Creating positive mental health outcomes in a communal living environment such as a shelter or transition house, as well as on an outreach basis, are key to service provision in these communities. This case study explores how women experiencing violence and abuse are now accessing services in rural and remote areas. It is a resource which will help focus the discussion among those who work in transition houses and outreach organizations that provide services and programs for IPV survivors.

The intent is that some new models for delivery will emerge – models that will be accessible, inclusive, and readily available in a rural or remote community setting. [2] This case study offers three community profiles that are examples of the range of rural and remote communities, the diversity of these communities, as well as a representation of the organizations and structures that are available to meet the needs of rural women. We will explore the gaps and challenges in supporting women survivors of violence, in particular those who have concurring mental health service needs. [3] We will also identify next steps for a model(s) that would provide optimum support.

[1] NOTE: "*To limit a foray into the debate surrounding definitions – for the purpose of this document the broad inclusive definition for rural and remote locations for practice is essentially…rural and remote is what is not classified as urban*."
http://www.carrn.com/files/NursingPracticeParametersJanuary08.pdf

[2] NOTE: "*…Remoteness can be interpreted as access to a range of services, some of which are available in smaller and others only in larger centres; the remoteness of a location can thus be measured in terms of how far one has to travel to centres of various sizes*."
www.health.gov.au/internet/main/publishing.nsf/.../ocpanew14.pdf

[3] The sections of this Case Study that deal with gaps and challenges, as well as next steps are also informed by workshops that included representation from service providers from New Brunswick, Prince Edward Island, Nova Scotia and Newfoundland and Labrador. (See Appendix A)

Case Study Outline

While police-reported spousal[4] violence has been declining steadily over the past 10 years, the statistics remain sobering. In 2007, more than 40,000 incidents of spousal violence were reported to police, representing 12% of all violent crimes.[5] However, the 2009 General Social Survey found that self-reported spousal violence was unchanged from 2004 with 6% of Canadians reporting incidents of spousal victimization in the preceding 5 years.[6] While men are sometimes the victims of family violence, the majority of victims, 84%, are women. Women are also four times more likely than men to be killed by an intimate partner.

Services to support the victims of IPV are insufficient, but some populations have better access to services than do others. Among those most likely to be underserved are rural and remote populations. According to Statistics Canada, 57% of shelters serve urban or suburban population and another 39% serve an urban-rural mix, but only 4% of shelters in Canada are geared exclusively for village or rural areas, including rural shelters serving reserves.[7]

The Atlantic Centre of Excellence for Women's Health (ACEWH,) in partnership with the Rural Research Centre (RRC) and the Transition House Association of Nova Scotia (THANS), has developed a case study on access to services for women survivors of intimate partner violence in rural and remote communities in Nova Scotia, and in particular how concurring mental health service needs are currently being met. The RRC at the Nova Scotia Agricultural College has a mandate to focus on rural, multi-disciplinary research in Atlantic Canada, and THANS serves as the umbrella organization for all of the women's transition houses and outreach services for IPV survivors in the province. This document will utilize the Homeless Individuals and Families Information System,[8] the Nova Scotia Department of Finance database, Community Counts, [9] as well as a literature scan of peer-reviewed and grey literature to round out the portrait of needs and services in rural and remote communities.

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[4] NOTE: clarification of definitions/terminology. The definition of spouse in Statistic Canada reports referenced in this document includes married, common-law, same-sex partners and where indicated, separated and/or divorced partners (at the time of the criminal incident). Our preferred terminology is Intimate Partner Violence (IPV). The official definition does not include dating relationships therefore the reported statistics do not provide a full picture of the extent of IPV. The 2009 report provides a profile of "shelters that provide residential services". The preferred terminology that we will use is transition houses to shift emphasis toward services of which shelter is just one. This refocusing will hopefully make the services more accessible if women realize they do not need to be a resident. Some reports refer to risk factors. The preferred term is contributing factors, which has less of a connotation of blame or fault.

[5] Statistics Canada. *Family Violence in Canada: A Statistical Profile, 2009*. Ottawa

[6] Statistics Canada. *Family Violence in Canada: A Statistical Profile, 2010, Ottawa*.

[7] Statistics Canada. *Family Violence in Canada: A Statistical Profile, 2009*. Ottawa

[8] http://www.hifis.ca/index-eng.shtml

[9] http://www.gov.ns.ca/finance/communitycounts/

Provincial Context

History

Services for abused women began in Nova Scotia in the mid-seventies in Halifax. In 1978, a group of concerned citizens opened Bryony House, the first transition house in the province. Sydney identified a similar need and the Cape Breton Transition House was opened in 1981.

Tearmann House in New Glasgow was opened in 1984 and Naomi Society began offering services to women in Antigonish County that same year.

Chrysalis House in Kentville, Juniper House in Yarmouth (which now includes the former CASA outreach organization, Juniper Digby Outreach in Digby,) and Harbour House in Bridgewater all opened in the next couple of years. These houses were the result of community initiatives to address the lack of adequate services and resources available to abused women and their children. We now have Third Place in Truro, Autumn House in Amherst, and Leeside Transition House in Port Hawkesbury.

All of these organizations resulted from community involvement and initiative. After identifying a serious need, these communities approached the Provincial Government and were successful in obtaining operational funding to provide services to victims of family violence.

In 1992, the Federal Government supplied funding to establish two Mi'kmaw Family Healing Centres, one in Whycocomagh and one in Millbrook.

The total number of beds available to women at transition houses in NS number 148, including the 16 on reserve beds for Aboriginal women. Of the 148 beds, 104 are located in rural Nova Scotia.

THANS was conceptualized at a New Glasgow meeting in 1984, when representatives of transition houses came from across the province to express common concerns about the battered women's movement. The Transition House Association of Nova Scotia (THANS) was incorporated under the Society Act in 1989 as a non-profit society, and is the provincial voice for issues related to intimate partner violence in NS.[10]

Funding

When funding was initially provided by the Department of Community Services (DCS,) Government of Nova Scotia, it was on a per diem basis, and through the municipalities. In the mid- nineties, THANS Member Organizations were switched to provincial block funding, which essentially provided (at that time) about 80% of the required funding need for salaries and operations. While there were yearly

[10] http://www.thans.ca

salary increases since then, there were no operational budget increases until the last fiscal year. Provincial funding includes salaries for executive directors, women's counselors, outreach workers, in-house childcare and relief staff, with the Full Time Equivalency (FTE) determined in the mid-nineties based on the number of shelter beds. Additional staff for programs not funded by DCS comes from the Law Foundation, the Canadian Women's Foundation, Status of Women Canada or other project funders, none of which fund ongoing programs or operations.

In Nova Scotia, programs and services offered by transition houses and outreach organizations operate in a stalled economic climate, with the current provincial government committed to getting their finances "back to balance,"[11] which will include a review of all not-for-profits funded by the Government over the 2011-2012 fiscal years. There is increasing administration, and accountability requirements from all our funders, a move from block funding to contracts for services (service level agreements,) and a draft of new Provincial Standards for Transition House Member Organizations is ready for ratification. All of these changes are occurring within the context of the newly released (December 2010) Domestic Violence Action Plan (DVAP.) [12]

As a result of the Report of the Domestic Violence Prevention Committee,[13] a Coordinating Committee comprised of a number of government agencies and departments developed the DVAP. Even though a consensus of government departments and not-for-profit organizations recommended the ongoing inclusion of community organizations in the development of the Plan, community involvement did not materialize.[14] The DVAP has a focus on government generated programming and services. THANS member organizations and other community-based services look forward to being part of the implementation of the plan.

Future decisions about provision of, or changes in, existing services may be made without consultation with existing service providers or the communities those organizations serve. The government's newly adopted "client-centred" approach to their program and services review mirrors a philosophy that has been a pillar of the community-based member organizations of THANS since their inception. To date, the provincial government has based funding and service provision decisions for rural shelters solely on the occupancy rates, indicating a lack of understanding or knowledge about the comprehensiveness of actual service provision, as well as to the barriers to shelter residency, particular for rural women. Transportation, lack of confidentiality of shelter locations, lack of personal confidentiality in small communities, women's access to their jobs, which might be some distance from the shelter, as might be the schools their children attend, all contribute to concerns about residential services. If women believe that they must be a resident of a shelter in order to access services, there exists a presumed but dangerous barrier, as shelters function in concert with outreach programs.

[11] Back to Balance: The Four Year Plan, http://www.gov.ns.ca/finance/site-finance/media/finance/budget2010/budgetaddress2010-11.pdf
[12] Domestic Violence Action Plan, http://premier.gov.ns.ca/wp-content/uploads/downloads/2010/12/Domestic-Violence-Action-Plan.pdf
[13] Report of the Domestic Violence Prevention Committee http://www.gov.ns.ca/just/global_docs/DVPC_recommendations.pdf
[14] Ibid

Legislation and Policy

Legislation under which THANS member organizations operate includes the Domestic Violence Intervention Act.[15] Part of the NS Government's response to the Review of the Framework for Action against Family Violence,[16] this legislation provides for transition house workers to act as agents for women applying for Emergency Protection Orders (EPOs.) While the women themselves, their lawyer (if they can access one) or police can provide the same service, experience has indicated that women will ask shelter staff for help with their EPO applications, if they know that staff are designated to do so.

In 2002, the Department of Justice introduced the High Risk Case Coordination Protocol Framework (HRCCPF,)[17] another response to the Review of the Framework. The goals of the HRCCPF are to increase victim's safety, reduce risk and avoid duplication of services. Information sharing, collaboration, planning and court case tracking are identified tools to achieve these goals. THANS Member Organizations, in collaboration with their five partners in the Framework, have been tasked to develop local protocols, which include but are not limited to, the Dr. Jacqueline Campbell Danger Assessment Test (used by community organizations,) the Ontario Domestic Assault Risk Assessment (ODARA, used by policing agencies,) coordination with their local Domestic Violence Case Coordinator, case conferencing and the sharing of critical incidents in high risk cases.

The Children and Families Services Act contains stringent requirements if children under our care are known to be witnesses to IPV. In particular, Article 22.2.i requires us to report to Child Protection if "…*the child has suffered physical or emotional harm caused by being exposed to repeated domestic violence by or towards a parent or guardian of the child, and the child's parent or guardian fails or refuses to obtain services or treatment to remedy or alleviate the violence*…"[18] There is no consistency in how government staff interpret this article, with regard to women using our services, which can, and has, created barriers in interpretation and implementation of a holistic plan for both mom and her children.

Other legislation and policy that impacts the work of THANS Member Organizations includes, but is not limited to Child Protection, Adult Protection, Infectious Disease, and Discipline, and the Canadian Association of Social Workers Code of Ethics, as well as the Motor Vehicle Act and Seatbelt Legislation, Occupational Health & Safety First Aid Regulations and Workplace Hazardous Materials Information System Regulation.

[15] Domestic Violence Intervention Act, http://nslegislature.ca/legc/statutes/domestcv.htm

[16] Government Response to Framework for Action against Family Violence, 2001 Review, http://www.gov.ns.ca/just/publications/docs/russell/govtresponse.htm

[17] High-risk Case Coordination Protocol Framework: Spousal/Intimate Partner Violence, Nova Scotia Departments of Justice and Community Services and Public Prosecution Service, 2002

[18] The Children and Families Services Act, Nova Scotia, http://nslegislature.ca/legc/statutes/childfam.htm

Mental Health

A recently released report by the BC Society of Transition Houses, prepared for the Canadian Women's Foundation,[19] referenced research studies that demonstrated that women`s experience of violence came before their mental health issues. The report also revealed that 50% of all women surveyed who had experienced violence had a clinical mental health diagnosis, compared to only 20% of women who had not experienced violence.[20] There was a noted difference in the "philosophies" of IPV services versus mental health services. For transition houses, women's empowerment and equality is often a guiding principle of service delivery. By contrast, mental health services are commonly influenced by the medical model, which often emphasizes pathology over strengths and reduces complex social problems to treatable diagnoses.[21]

These studies mirror the experiences of THANS Member Organizations. Increasingly, transition houses in Nova Scotia find that women survivors of intimate partner violence are asking for support with mental health concerns, many of which are complex and chronic. Access to services in rural and remote areas for women experiencing intimate partner violence are further exacerbated by the lack of, or limited access to, mental health supports; staff`s concerns about their expertise in addressing increasingly complex mental health illnesses in a communal living environment or on an outreach basis; little or no access to long term counseling and support groups; lack of understanding and fear from other service users ,which can result in at-risk women leaving shelters and returning to abusive relationships; and most significantly, women`s fear that their mental health issues could result in the apprehension of their children. [22]

Currently, NS is developing a Mental Health Strategy. Consultations are being held across the province with interested parties, using the Mental Health Strategy Background document as a guide. [23] To date, this "living" document has one reference to counseling for family violence, under a description of services offered by the Eskasoni First Nation.[24] There are no references to the link between mental health and intimate partner violence. THANS Members are participating in focus groups across the province and will address the current lack of collaboration between IPV and mental health service providers.

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[19] Report on Violence Against Women, Mental Health and Substance Use, BC Society of Transition Houses, February 2011

[20] Ledermir, A., Schraiber., L., D'Oliveira, A., Franca-Junior, I., Jansen, H. (2008). Violence against Women by their Intimate Partner and ommon Mental Disorders. *Social Science & Medicine, 66*(4), 1013

[21] Humphreys, C., Thiara, R.K., Regan,L. (2005). Domestic violence and substance use:overlapping issues in separate services? http://www2.warwick.ac.uk/fac/soc/shss/swell/research/final_report.pdf

[22] Becker, M.A., Noether, C.D., Larson, M.J., Gatz, M., Brown, V., Heckman, J.P., Giard, J. (2005). Characteristics of women engaged in treatment for trauma and co-occurring disorders: Findings from a national multisite study. *Journal of Community Psychology, 33*(4), 429-443

[23] Mental Health Strategy Background Document: A Summary of the Current State of mental health and addiction services in Nova Scotia, February 18, 2011 http://eros.lunarpages.com/~openpo2/SSNS/Mental%20Health%20Strategy%20Background%20Document.pdf

[24] Ibid, page 59

Homeless Individuals and Families Information System

THANS uses HIFIS, a statistical database reflecting shelter and services provided to victims of IPV in their member organizations. THANS has been using the Homeless Individuals and Families Information System (HIFIS) for five years and over the last three has been able to collect, on a provincial level, basic non-identifying information on unique clients. Most of the member organizations are also using HIFIS to reflect the goods and services that are identified as necessary by our service users and provided by our staff. Currently, THANS is working with NS government staff to develop a new reporting mechanism using HIFIS data that will monitor and evaluate service delivery.

HIFIS includes the capacity to develop, input and analyze surveys to reflect past, current and potential service users' needs in terms of positive mental health outcomes. The Health Module in HIFIS can also be used to track women's sharing of their mental health concerns, and can indicate whether those needs are self-identified, diagnosed or suspected. The identified pilot locations are committed to increasing their use of HIFIS to reflect both the service users' concerns, the services provided by staff to sustain or increase positive mental health outcomes, and any identified gaps that need to be addressed.

Below we have provided an overview summary drawn from three years of HIFIS data. This summary is also attached as Appendix E. The data demonstrates a constant need and use for services.

2008-2010 THANS Statistics

Nova Scotia's (THAN's) nine off-reserve shelters have a total of 132 beds.

HIFIS Statistics	*2008*	*2009*	*2010*
# of Unique Individuals	971	932	969
# of Admissions	1,112	1,109	1,188
Total # of shelter Nights	22,824	21,172	20,665
Average length of Stay	18	20	21
# of Moms	337	317	315
# of children	368	321	354

Types of Services*	Percentage		
	2008	2009	2010
Information & Referrals	4	4	35
Counselling	63	71	33
Advocacy	14	7	18
Criminal Justice Services	6	3	4
Support Groups	2	3	4
Transportation	3	9	3
Childcare	8	3	3

**these percentages reflect only those shelters who provided goods and services information*

Reason for Service**	2008	2009	2010
Partner Abuse, Psychological	52%	40%	49%
Partner Abuse, Physical	29%	33%	30%
Partner Abuse, Sexual	5%	3%	7%
Relationship Breakdown	18%	24%	14%

***Only one "reason for service" is recorded, though most service users experience more than one type of abuse*

Reasons for Discharge	2008	2009	2010
	By Percentage		
To Family and Friends	31	26	29
Housed* **	21	30	27
Back to Abusive Partner	26	20	21
Another Shelter	9	3	7
Left Area	4	8	6
Hospital/Treatment	3	1	3
Suspended/Barred	3	4	3
Other	3	8	4

****** Housed in private market, affordable, supportive or supported housing***

The Majority of Women and Children stay at a THANS shelter only once:

2008			2009			2010		
Residents	**Stays**	**%**	**Residents**	**Stays**	**%**	**Residents**	**Stays**	**%**
807	1	87	820	1	87	832	1	86
92	2	10	94	2	10	102	2	11
~~18~~	~~3~~	~~2~~	~~18~~	~~3~~	~~2~~	~~20~~	~~3~~	2
15	4+	1	10	4+	1	15	4 +	1

Three Year Age Breakdowns for Residents:

Age of							
	16-19	20-29	30-39	40-49	50-59	60 +	TOTALS:
WOMEN	137	530	443	461	176	82	1,829
Other*	0	0	0	0	0	0	
CHILDREN	1-2	3-4	5-7	8-12	13-16	16 +	
Girls	135	81	93	126	61	38	534
Boys	159	93	83	100	54	20	509
						TOTAL:	2,872

Pilot Communities

The ACEWH, the RRC and THANS identified three transition house communities in NS for inclusion in this study: Chrysalis House in Kentville; Leeside Transition House in Port Hawkesbury; and Juniper House in Yarmouth.

Chrysalis House, established in 1985, provides crisis and transitional services, including shelter, support, information, advocacy and outreach for women who have experienced violence and abuse and their children. Serving the counties of Annapolis, Hants West, and Kings, Chrysalis House is funded by the Department of Community Services for a 15 bed shelter.

Leeside Transition House, built as a shelter in Port Hawkesbury in 1992, provides safe shelter and services to the town of Port Hawkesbury and the counties of Richmond and Inverness. Although officially not part of our catchment area, we also provide services to women from across the causeway (Mulgrave, Guysborough and Antigonish Counties) and to women from Victoria County.

Juniper House, established in 1985, is a 15-bed shelter for women and their children leaving abusive and violent relationships. Juniper House provides crisis and transitional services, 24/7, to women in Yarmouth, Digby and Shelburne Counties.

By situating the transition houses within communities we include community profiles built on information from Community Counts, overviews of each areas by the Executive Directors of each shelter; maps from Community Counts indicating the general areas where transition houses are located. Criteria for inclusion as a pilot community included catchment areas that:

- are almost entirely rural and remote, by our definitions
- include Acadian, Aboriginal and African Nova Scotian communities
- cover large geographic areas that require a focus on outreach

- experience the barriers of lack of transportation, lack of confidentiality of shelter locations, lack of personal confidentiality in small communities, women's access to their jobs, which might be some distance from the shelter, as might be the schools their children attend

- include a transition house where a town has a relatively high level of services for women(Chrysalis House,) an area where there are no other specific services for women (Leeside Transition House) and one with a catchment area so large (Juniper House,) that a satellite non-shelter facility is required

- reflect the total transition house coverage for the counties of Yarmouth, Digby, Shelburne, West Hants, Kings, Annapolis, Richmond and Inverness Counties

Conclusion

"Every domestic violence/sexual assault program has strengths and challenges impacting our ability to provide services. Unfortunately many advocacy programs are under-equipped to address co-occurring issues impacting women's safety and health. In order to better extend services and advocacy to battered women with separate issues, we must expand our current practices and explore new strategies to address safety and support wellness."[25]

Providing access to concurrent and accessible mental health services, either in-house or by referral is a vital part of NS transition houses` commitment to holistically addressing the needs of women survivors of IPV in rural and remote areas. The economic climate, and frozen or lowered funding for non-governmental organizations, and lack of growth (to date) of mental health services in rural and remote areas, are all combining to make provision of these services by THANS Member Organizations a priority.

Development of an integrated model of services for THANS Member Organizations in rural and remote areas, that will meet both the IPV and mental health needs of women service users, will require the collaboration of local and provincial non-governmental partners, the Division of Children, Youth and Families of the Department of Community Services, the Department of Health and Wellness and other provincial government departments. In order to maintain any benefit of a new model, THANS Member Organizations will need to ensure that much of the new capacity to create positive mental health outcomes can be replicated on an ongoing basis, within our own organizations.

Recognition of, and attention to the emerging Mental Health Strategy will be important, as will monitoring of any changes to legislation and policy as it impacts IPV and/or mental health in NS.

[25] Haskell, R. (2010). Reducing Barriers to Support: Discussion Paper on Violence against Women, Mental Wellness and Substance Use.BC Society of Transition Houses

Most importantly, future service provision needs to be informed by past, current and potential service users, and reflect women's identified needs and solutions. "*Women-Centred Care is based on the assumption that women know their own reality best and that practitioners must listen carefully to women describe their reality in their own words and in their own way*."[26]

On a three year timetable and focusing on our Pilot Locations, we will:

1. Using surveys and focus groups, categorize the services that women experiencing IPV, with concurring mental health needs, identify as important, at THANS Member Shelters and outreach organizations, and when they leave the shelters.

2. Using surveys and focus groups and collaborating with mental health service providers in the area, categorize the services that women experiencing IPV, with concurring mental health needs, and who are potential users of our services, identify as important

3. Review current models of service, in other jurisdictions, that work with women in a holistic manner and support their identification of positive outcomes for IPV and mental health

4. Work with partners to create capacity in rural and remote areas for delivery of concurrent mental health services to women receiving services for IPV

5. Determine optimum methods for creating capacity for service providers to work holistically with women to create positive mental health outcomes

6. Create programming that will increase all service users' understanding of the mental health impacts of IPV

7. Develop and test an modified "Integrated Hub Model" of service provision that addresses co-occurring IPV and mental health wellness at our three test locations[27]

8. Undertake an external evaluation of the Integrated Hub Model

9. Workshop and finalize an Integrated Hub Model of service provision that can be adopted by THANS Member Organizations, and easily adapted to the needs of our colleagues in the rest of the Atlantic Provinces.

[26] Cory, J., and Dechief. L. (2007). SHE Framework: Safety and Health Enhancement for Women Experiencing Abuse: A Toolkit for Health Care Providers and Planners. Vancouver, BC: BC Women's Hospital and Health Care Centre and BC Institute against Family Violence.
[27] http://ruralvoices.cimnet.ca/cim/86C179_268T25704.dhtm

Appendices

A: The Wilds Consultation

The ACEWH and the RRC hosted a two day workshop at the Wilds, in Salmonier River, NL, to workshop the Case Study in its early stages and to provide an opportunity for the study to be informed by practitioners from both the IPV and Mental Health sectors in all of the Atlantic Provinces. Using the "World Café" process, there was an open discussion of both the draft case study in Nova Scotia as well as overviews of the current situation in the other three provinces. The consultation broadened and improved the perspectives reflected in the Case Study, and renewed the commitment to create a model that can be adapted for use across the Atlantic Provinces.

Thank you to:
Ellen Ridgeway, ED Transition House, PEI
Pamela Harrison, coordinator, THANS NS
Lisa Newell, ED Juniper House NS
Dianne Power, ED Transition House NB
Noreen Careen, NL Advisory Council Status of Women, Labrador City, NL
Denise Cole, Community Ec Devt & Women's Committee Goose Bay, Labrador, NunatuaKavut
Tracy Ann Evans, Status of Women, Nunatsiavut, Makkovik NL
Kathleen Jason, ED Transition House, Cornerbrook, NL
Marie Rich, ED Transition House, Rigolet, Labrador
Deborah Stiles RRC NS
Chloe Kennedy RRC NS
Barbara Clow, ACEWH NS
Linda Snyder ACEWH NS

(Atlantic workshop included participation from NS, PEI, NB, Newfoundland and Labrador, which included executive directors, researchers, coordinators of transition house associations, and four participants from Labrador, including Nunatsiavut and NunatuaKavut.)

Summary

Participants shared information about their respective work in women's transition houses and women's health. Themes included the problem of isolation in remote and rural communities (Labrador and NFLD), the effect of abuse and mental strain on physical ailments (ie: cancer), summaries of preliminary barriers and opportunities in the various Atlantic Provinces. Participants were interested to share and gain knowledge of models around mental health in other jurisdictions. We need to understand how it's dealt with in each sub region within the Atlantic. Participants identified the need to look at best

practices and to have opportunities to learn about what's happening in other parts of the Atlantic region. People also wanted to explore some ideas for future research which could include those most affected. An important aspect of the discussions was the opportunity to collaborate, to meet each other and get to know each other's work. Finally participants wanted to talk about best practices and the need to recognize the value in our work and in sharing knowledge and experiences. The participants wanted to work on a shared agenda for research and program development. There is an ongoing commitment to build a lose network within the Atlantic, especially with respect to rural and remote locations and the mental health needs of women and their children who are dealing with intimate and domestic violence. Everyone volunteered to review and help disseminate the final report.

B: Pilot Location Overviews

Chrysalis House Overview

Chrysalis House, established in 1985, provides crisis and transitional services, including shelter, support, information, advocacy and outreach for women who have experienced violence and abuse and their children. Serving the counties of Annapolis, Hants West, and Kings, Chrysalis House is funded by the Department of Community Services for a 15 bed shelter.

Facility

Chrysalis House is a 150 year old three story building. There is one wheelchair accessible bedroom and bathroom. All bathrooms are communal. The basement, with a rock wall foundation, is very wet and provides limited usable storage space. The first floor has three offices one bedroom, living room, dining room, kitchen, staff and resident washroom and laundry room. The second floor houses four bedrooms, a small lounge area, one washroom and limited locked storage space. The third floor houses not only a playroom, but also the in-house children's worker and children's outreach worker offices, a washroom and a kitchen area.

Programs

Chrysalis House provides crisis and transitional services, including shelter, support, information, advocacy and outreach for women (and their children) that have experienced violence and abuse, with a maximum six week in-house stay. Public education and community development are also important elements of our Association.

Chrysalis House is funded by the Department of Community Services, Province of Nova Scotia. The 'approved' budget is never sufficient to meet even our basic expenditures; therefore, fund-raising is critical to the wellbeing of our organization. The Public Health Agency of Canada largely funds our Children's Outreach Program, one component of the Annapolis Valley Hants Community Action Program for Children.

Community Outreach

Outreach services, offered to women and children, offer individual and group support, advocacy, referral and information. The women's outreach worker also assumes primary responsibility for coordination of high risk for lethality cases within our organization.

Staff

Executive Director
Four full time shelter staff
One children' in house worker
One women's outreach worker
One children' outreach worker
Four relief workers
All staff (except ED) are unionized with Public Service Alliance of Canada (PSAC)

Current Imperatives

- In order to keep up with the demands placed on our organization we must raise a minimum of $50,000 per year. Within the current economic climate, the sustainability of this level of fundraising is in question.
- The shelter is currently single staffed. This is a safety issue for both staff and residents, particularly when some service users have chronic mental health challenges.
- There is a dire need for increased outreach services, as it is very difficult to reach two and a half counties with one worker.
- As the only year round 24/7 shelter, we are often called upon to offer services in cases that only loosely fit our mandate. While we do what we can to assist all women, our resources are limited.
- Addressing the provision of residential emergency services for homeless women
- Staff training, particularly to increase capacity to address mental health needs

Industry and Employment

Chrysalis House is located in Kentville, Nova Scotia. With a population of just over 95,000, our catchment area is primarily agricultural. Manufacturing has been a stable source of employment in Kings County but the last few years have seen the loss of hundreds of jobs in the chicken and pork processing plants. In Annapolis County, population has been steadily declining. A call centre that provided employment to several hundred people has recently announced closure for the spring of 2011.

Transportation and Housing

Transportation is of huge concern to residents of our area, particularly those living with poverty. Bus service is only available along the main areas while many subsidized and low rent housing units are 'off the beaten path'. Chrysalis House and other non-governmental organizations spend time and money ensuring that families can access programs and services. Our area also includes Wolfville, home of Acadia University. This keeps rental rates high in our area. There is a lack of affordable housing and the waiting list with the local housing authority is several years long.

Education

Both Acadia University and the Kingstec campus of the Nova Scotia Community College are located within Kings County. A number of community based organizations, such as PeopleWorx and Valley Community Learning Association are also located nearby.

A number of high schools are also located within our catchment area. The high school that provides service to the town of Kentville (Northeast Kings Education Centre) is located approximately 15 km away in Canning. This poses a challenge for families as there is no public transportation between the two communities.

Culture

Chrysalis House catchment area includes three First Nations reserves: Glooscap in Hantsport, Annapolis Valley in Cambridge and Bear River (located partially in Chrysalis and partially in Juniper catchment area).There are a number of small African Nova Scotian communities, including Lequille and Meadowview. A number of migrant workers from the Caribbean and Mexico have become seasonal members of our community as they return each year as farm labourers. Many of these workers have children that are permanent residents of our area with their mothers.

Urban/Rural Influence

While parts of our catchment area are more rural, Kentville is a small town that has begun to display more urban characteristics. With an increase in the number of those experiencing long-term mental health issues and homelessness, the community struggles with meeting needs across a spectrum of challenges. Valley Regional Hospital is located in Kentville and is a primary care facility for most of the Annapolis Valley and beyond. The presence of an active drug trade and a methadone clinic that lacks surrounding supports invites challenges that may be traditionally considered 'city' issues. With only a one-hour travel time into Halifax, Kentville is also seen as attractive to women who feel the need to leave unsafe situations in Halifax for a quieter alternative.

Because of the rural nature of many parts of the Annapolis Valley, confidentiality is always a challenge as friends and neighbours easily note any change in routine. Often families have lived in rural areas for many generations making change difficult. West Hants County, on the other hand, is located approximately 50 km from Halifax Regional Municipality. Many services are located in Halifax. This may be problematic for some residents as much of this area is very rural in nature. Some do not wish to travel to 'the city' for services.

Health Services

Our area is served by Valley Regional Hospital. Mental Health services are also provided by Annapolis Valley Health. These services do not meet the need of those who are living with persistent mental health issues. There is also a lack of crisis based services for this population. A branch of the Canadian Mental

Health Association is located in Kentville. As a small, not for profit organization, they too struggle with a lack of resources.

Social Challenges

Unemployment, drug trade, and homelessness are issues in our area. Due to our 'rural' area adequate services to address homelessness are not in place. Despite a research project on the issue of homelessness in the Annapolis Valley, there are still no sustained services directly related to homelessness in our area. Due to the number of services available, many people who would not move to the Halifax area choose to move to Kings County. This creates a population with an urban demographic that only has access to services that are rural in scope and practice.

Community Collaboration

We have a mix of rural and urban living within our catchment area. Our community works well collaboratively on both a formal and informal basis. Relationships between Chrysalis House and other service providers are positive. Change comes slowly in our community where most people have roots in the area and others remain 'come from aways' no matter how long their residency.

Juniper House Overview

Juniper House, established in 1985, is a 15-bed shelter for women and their children leaving abusive and violent relationships. Juniper House provides crisis and transitional services, 24/7, to women in Yarmouth, Digby and Shelburne Counties.

Facility

Juniper House was built before 1863, and is funded by the Nova Scotia Department of Community Services for fifteen beds. It has five bedrooms, 2.5 bathrooms, a program room, resident's computer, children's playroom, living room, kitchen, donation room and a furniture bank. The House has three offices and a large fully enclosed back yard with a deck, bbq and children's playground equipment. The first floor of the shelter is wheelchair accessible and has an accessible bathroom.

Programs

Shelter and Crisis Line

Juniper House offers 24 hour safe shelter with video surveillance and an alarm system. The House operates a 24 hour crisis line and has an open door policy where past residents can stop by for ongoing support.

Community Outreach

Juniper House operates outreach offices in the towns of Digby and Shelburne with outreach services extending out to the greater communities. Outreach services include, but are not limited to, counseling, individual and group sessions, court accompaniment, advocacy and support and community information sessions. We offer a summer day camp, free of charge to children 6- 11 years of age, where we offer activities and recreation and crafts, as well as programs that address appropriate anger expression, self-esteem and anti- bullying,

Staff

Executive Director
Four full time Transition House Workers
Three part time Transition House Workers
One Relief worker
One full time Children's Services Worker
Three full time Outreach Workers
All staff (except the Executive Director) are unionized with the Canadian Union of Public Employees (CUPE)

Current Imperatives

- Continue to offer the highest quality of service to women and their children leaving abusive relationships.
- Enhance and expand existing programs and outreach services for abused women and their children within the catchment area, particularly those in more outlying areas or culturally distinct areas such as the Acadian Communities, as well as to youth.
- Provide more workshops within the community and establish and enhance more community partnerships and networks with existing agencies.
- Repair and maintenance work to house to ensure safety and the home's integrity and improve accessibility for persons with disabilities.
- Lack of 100% core/block funding is an ongoing challenge
- Staff training, particularly to increase capacity to address mental health needs

Community Overview

Juniper House serves Yarmouth, Digby and Shelburne Counties, with a population base of approximately 60813 (2006) and a geographic area of approximately 7103 square kilometres including an Acadia First Nations Community as well as the Acadian Communities of Pubnico, Argyle, and Clare. Eleven Municipal Units are included in our catchment area. In 2006 the merger with Citizens against Spousal Abuse (CASA) was completed and CASA became Juniper House Digby Outreach.

Industry & Employment

The Tri-counties are a coastal area, with industries including lobster fishing, scallop dragging, shellfish harvesting, herring, tuna and other fish products. There are many fishermen and fish dealers, and those in fish processing, as there are many processing plants in the area, and processing of other sea products such as seaweed. There are large boat builders still operating in Clare and Shelburne counties.

Farming remains an active industry in the Tri- counties. We have a lot of dairy production in the area. Local agricultural products are grown, and farmers markets are becoming more and more frequent with a growing emphasis on eating local. We have two call centers in our area: Register.com is located in Yarmouth County and Convergys is located in Digby County. The call centers remain a large employer for younger workers in our area, employing approximately 300 workers.

Tourism was once a major industry in the area but with the shutdown of the Cat ferry and the transportation corridor from Maine, recent years have seen a steady decline, and rising unemployment, with hotels, restaurants, shops and businesses closing. Many workers, especially young workers, have gone west to seek employment. Unemployment remains high.

Transportation & Housing

Public transportation is nearly nonexistent at this end of the province. King's Transit has a route from Weymouth to Wolfville. Acadian Lines travel from Digby to Halifax. Yarmouth struggles to maintain an airport and air service: currently Twin Cities Air Service operates out of the terminal. There is an accessible van service that operates throughout the municipality of Clare, the Transport du Clare, which transports persons with disabilities within Clare and to Digby and Yarmouth for medical appointments and care. There are private shuttle services that operate between Yarmouth and Halifax, which are becoming increasingly expensive due to fuel prices, and there are private taxi services in Yarmouth and Digby. Yarmouth no longer has a ferry service, train, or bus service. There is no service that links Yarmouth, Shelburne, and Digby counties.

Safe affordable housing is at a premium. Recently Yarmouth experienced a housing crisis with many rental properties having their mortgages foreclosed and tenants evicted en masse. The Regional Housing Authority and Coboquid Housing offer units in the area.

Education

Our school boards remain a major employer in the area, though declining classroom size and restructuring continues to be an issue. We have the Tri- County Regional School Board and the Acadian School Board. French emersion programs are offered in some schools within the Tri County Regional School Board. NSCC Campuses are located in the towns of Yarmouth, Shelburne (full campuses) and Digby (satellite campus). The University St. Anne is located in the Municipality of Clare with a satellite

campus in the Municipality of Argyle. St Anne offers university programs and is a large employer in the French communities.

Culture

Our area is rich in culture and has a sea faring history. Yarmouth is celebrating its 250th Anniversary this year. We have many museums, lighthouses and the Art Gallery of Nova Scotia has a branch in Yarmouth. There are playhouses in Yarmouth and Shelburne. We have strong Acadian Communities in the municipalities of Clare and Argyle, and the Acadia First Nations in five small Reserves across the three counties. The Black Loyalist community of Birchtown is located in Shelburne County.

Urban/Rural Influence

The area is very rural and in some instances remote, with areas that are only accessible by bridge or ferry. Protocols for quick transportation of women (and their children) in emergencies have been established with ferry services in the Digby area. The closest urban centre is Halifax, which is 3.5 hours driving from Yarmouth.

Health/Mental Health Services

The Regional Health Centre is located in Yarmouth with smaller hospitals in Digby and Shelburne The municipality of Clare has recently opened a health centre. Many people are without family doctors, which mean emergency services have greater wait times as many people must go to emergency rooms for routine activities. Nurse Practitioners are used in some of the more remote areas with some success.

Mental Health Services are available in Yarmouth, Shelburne and Digby hospitals, Monday- Friday 8:30am- 4:30pm, though no mental health services exist in the Tri-county area outside the three rural centres. Though there is a self-referral process for mental health services, wait times can be 3-6 months. Individuals in crisis must go to the general emergency rooms at the hospitals, which are very public and have wait times that are often too long for persons experiencing mental health issues. Emergency departments in Shelburne and Digby counties close from time to time due to a lack of physicians so people in those areas have to travel at least an hour to get to the next emergency centre.

The only Withdrawal Management (Detoxification) program for the area is in Yarmouth, with the next closest in Middleton. Addictions services are offered on an outpatient basis by appointment throughout the Tri –counties, with some in patient services available for addictions in Yarmouth.

Social Challenges

There is an increasingly aging population, with a decline in younger workers in the area due to lack of employment and opportunities for employment in the western Provinces Teenage pregnancy rates remain high in the area.

Leeside Transition House Overview

Leeside Transition House, built as a shelter in Port Hawkesbury in 1992, provides safe shelter and services to the town of Port Hawkesbury and the counties of Richmond and Inverness. Although officially not part of our catchment area, we also provide services to women from across the causeway (Mulgrave, Guysborough and Antigonish Counties) and to women from Victoria County.

Facility

Leeside is funded by the Department of Community Services (DCS) for nine adult beds but with cribs and cots we can accommodate up to 15. The shelter has 4 large family bedrooms on the top floor and a smaller single room on the ground floor that is wheelchair accessible and has its own bathroom. The four other bedrooms share two full bathrooms and a powder room. Common space includes two living rooms, a reading nook, a large kitchen, a laundry room, a children's playroom and a fenced in back yard with a patio. There are also three offices and an office/meeting room located in the shelter. The ground floor is wheelchair accessible. The shelter is protected by the usual restricted entry, alarm system and video surveillance.

Outreach

Most of the work of Leeside can be described as outreach services. We have a full time outreach worker who travels to all the communities in our catchment area. The child support worker also does some of her work outside the shelter and many of our clients use the 24 hour phone line to access support. Any of the staff, including the executive director augment the work of the Outreach worker by meeting with clients outside of the shelter or go to court or appointments with clients.

Staff

Executive Director
Four Crisis Support Counselors
One Outreach Worker
One Children's Support Counselor
Five Relief Crisis Support Counselors
One part time bookkeeper/admin assistant
Staff are trained to be able to offer any of the services Leeside provides. The executive director is on call 24 hours and typically spends 40% of her time in direct service delivery

Current Imperatives

- Continue to provide the range of shelter and outreach services offered. Challenges are finding adequate funding and finding qualified staff. Most of Leeside's funding comes from DCS but we are required to supplement DCS funding with fund raising. In recent years it has become more

challenging to find and keep qualified relief staff. It has been especially difficult to find staff who speak both French/English.

- Continue to provide public education and increase community awareness of services.
- DCS, Public Health and Addictions all are making major changes to their service delivery models. Leeside is viewed by DCS as being under-utilized and seems to have an expectation that we fill some of the gaps identified by other service providers in the community. This is still in the discussion phase.
- Leeside Society is planning to expand its mandate to include services to all women. We have entered into a one year partnership with the Antigonish Women's Resource Centre to do a project that we hope will lead to Leeside providing services full time to all women.

Industry and Employment

Unemployment in the town of Port Hawkesbury and the counties of Richmond and Inverness is well above the provincial average. Although people are still employed in the fishery, forestry and agriculture, the numbers are a fraction of those employed in the past. A significant number of workers are employed seasonally in the tourism industry. During the Alberta boom a large number of men went to work in Alberta, while their families stayed in the area. The community is still suffering from the after effects when the Alberta jobs and the high wages disappeared and families found themselves not only without income but with considerable debt. Most of the "heavy" industry is centered around Port Hawkesbury although there are some smaller plants in the outlying areas. Although there are always rumours of plants closing, we seem to be in a period of relative stability.

Transportation & Housing

One of the biggest challenges for residents and those providing services is the lack of transportation. This has been slightly alleviated by the establishment of the Strait Area Transit Co-operative Ltd. (SAT). SAT operates a bus twice-daily between communities in Richmond County and Port Hawkesbury, Mulgrave and Port Hawkesbury, and has just added a daily run between Port Hood and Port Hawkesbury. Pleasant Bay is the farthest point of the catchment area and is a 2 1/2 hour drive from the shelter.

In Port Hawkesbury, there are a significant number of single parent families living below the poverty line. Safe affordable housing is almost nonexistent and most rentals are priced well above the income assistance housing allowance.

Education

Most communities have managed to hold on to their elementary schools but the community-based high schools were closed and replaced by larger regional schools. The Nova Scotia Community College

(NSCC) has a campus in Port Hawkesbury. Universite de Sainte Anne has two virtual campuses in Petit de Grat and Grand Etang. The closest universities are in Sydney and Antigonish.

Culture

The area is rich in culture. There is a strong and vibrant Acadian community with the bulk of French speaking persons living around Cheticamp and I'sle Madame but with smaller pockets in River Bourgeois and Samsonville/French Cove. Another significant group are those of Scottish descent. There are still pockets of people whose first language is Gaelic and Gaelic is taught in two of the schools in Inverness County. There are two First Nations Communities in our catchment area (Waycobah and Potlotek). More recently, we have welcomed new Canadians who speak German, Arabic and Chinese.

Urban/Rural Influence

Most of our catchment area is very rural and some areas are extremely isolated. Our catchment area has several identifiable villages and towns. The largest urban area is Port Hawkesbury and it offers the largest concentration of housing, services and business in our catchment area. A segment of the population is very transient and the town does not have the strong feeling of community that is found elsewhere throughout the catchment area. In terms of services and business, St. Peter's is the next most significant community in our catchment area. However, it is still very much a village and can't be described as being urban. Other significant areas are Inverness, Port Hood, Cheticamp and Arichat.

Health /Mental Health Services

Health services are provided by the Guysborough Antigonish Strait Health Authority (GASHA) and the Cape Breton District Health Authority (CBDHA). The types of services, service delivery and access to services can vary quite a bit between the two authorities. There is a hospital in Inverness, Cheticamp and 10 minutes outside of Port Hawkesbury. The hospital in Inverness has limited ability to do surgery. None of the hospitals in the catchment area provide obstetrics and women are required to travel to Antigonish or Sydney for these services. Mental health services consist of a satellite office with a social worker for each of the three hospitals. For in-patient services or to see a psychiatrist, people have to go to Sydney or Antigonish.

C: Data from Community Counts, by Counties in Catchment Areas[28]

Chrysalis House

Annapolis County

Based on the 2006 Census of Population, Annapolis County has a population of 21,440 which is 4.0% lower than in 1996. In 2006, 21.2% of the population was under the age of 20 and 20.1% was 65 years or older.

In 2006, for Annapolis County, total census families increased 4.0% to 6,500. Married families decreased by 3.6% while common law families increased 39.3% and lone-parent families increased 7.6%. Lone female parent families were 10.1% of all families while lone male parents were 2.7% of all families.

Compared to Nova Scotia, Annapolis County has a relatively high immigrant population. In 2006, there were 1,375 immigrants which is 6.5% of the population compared to 5% immigrants for Nova Scotia. In Annapolis County, 97.9% of people were Canadian citizens compared to 98.3% for Nova Scotia.73.6% of Annapolis County's population was born in the province of their residence.

English is the predominant language in Annapolis County, with 99.2% speaking only English in the home and 97.7% speaking only English at work

In 2006, the average income for individuals in Annapolis County was $25,763 a year, compared with the average of $31,795 for Nova Scotia. Families in Annapolis County had an average income of $52,643, compared with the average of $66,032 for Nova Scotia.

A total of 10.9% of families in Annapolis County had low income status in 2006, compared with 17.7% in 1996.

Hants County [29]

Based on the 2006 Census of Population, Hants County has a population of 41,180 which is 4.3% higher than in 1996. In 2006, 25.4% of the population was under the age of 20 and 13.8% was 65 years or older.

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[28] *All information taken directly from Nova Scotia Community Counts:* http://www.gov.ns.ca/finance/communitycounts/profiles/community

[29] NOTE: There is no breakdown for Hants East and Hants West, so data is for the whole county http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1208

In 2006, for Hants County, total census families increased 4.3% to 11,435. Married families increased by 2.0% while common law families increased 42.3% and lone-parent families increased 30.2%. Lone female parent families were 11.5% of all families while lone male parents were 3.1% of all families.

Hants County has a relatively low immigrant population. In 2006, there were 1,540 immigrants which is 3.8% of the population compared to 5% immigrants for Nova Scotia.

English is the predominant language in Hants County, with 99% speaking only English in the home and 98.5% speaking only English at work.

In 2006, the average income for individuals in Hants County was $30,536 a year, compared with the average of $31,795 for Nova Scotia. Families in Hants County had an average income of $61,406, compared with the average of $66,032 for Nova Scotia.

A total of 7.3% of families in Hants County had low income status in 2006, compared with 12.9% in 1996. In Nova Scotia, 10.3% of families had low income status in 2006, compared with 16% in 1996.

Kings County[30]

Based on the 2006 Census of Population, Kings County has a population of 60,035 which is 1.4% higher than in 1996. In 2006, 24.3% of the population was under the age of 20 and 15.4% was 65 years or older.

In 2006, for Kings County, total census families increased 1.4% to 16,790. Married families decreased by 1.3% while common law families increased 47.2% and lone-parent families increased 25.5%. Lone female parent families were 12.1% of all families while lone male parents were 3.0% of all families.

Compared to Nova Scotia, Kings County has a relatively low immigrant population. In 2006, there were 2,635 immigrants which are 4.4% of the population compared to 5% immigrants for Nova Scotia. In Kings County, 98.7% of people were Canadian citizens compared to 98.3% for Nova Scotia. 73.7% of Kings County's population was born in the province of their residence.

English is the predominant language in Kings County, with 99.1% speaking only English in the home and 98.2% speaking only English at work.

In 2006, the average income for individuals in Kings County was $29,279 a year, compared with the average of $31,795 for Nova Scotia. Families in Kings County had an average income of $59,646, compared with the average of $66,032 for Nova Scotia.

[30] http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1207

A total of 10.4% of families in Kings County had low income status in 2006, compared with 14.6% in 1996.

Juniper House

Yarmouth County[31]

Based on the 2006 Census of Population, Yarmouth County has a population of 26,275 which is 3.8% lower than in 1996. In 2006, 23.3% of the population was under the age of 20 and 16.7% was 65 years or older.

In 2006, for Yarmouth County, total census families decreased 3.8% to 7,940. Married families decreased by 5.7% while common law families increased 38.6% and lone-parent families increased 2.9%. Lone female parent families were 12.8% of all families while lone male parents were 2.7% of all families.

In Nova Scotia, total census families increased 5.3% to 1,190. Married families increased by -1.4% while common law families increased 43.2% and lone-parent families increased 14.1%. Lone female parent families were 12.8% of all families while lone male parents were 2.7% of all families.

Compared to Nova Scotia, Yarmouth County has a relatively low immigrant population. In 2006, there were 760 immigrants which are 2.9% of the population compared to 5% immigrants for Nova Scotia.

English is the predominant language in Yarmouth County, with 89.5% speaking only English in the home and 86.1% speaking only English at work.

In 2006, the average income for individuals in Yarmouth County was $27,740 a year, compared with the average of $31,795 for Nova Scotia. Families in Yarmouth County had an average income of $57,994, compared w

A total of 10% of families in Yarmouth County had low income status in 2006, compared with 15.7% in 1996. In Nova Scotia, 10.3% of families had low income status in 2006, compared with 16% in 1996.

[31] http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1202

Digby County[32]

Based on the 2006 Census of Population, Digby County has a population of 18,995 which is 7.3% lower than in 1996. In 2006, 20.7% of the population was under the age of 20 and 19.2% was 65 years or older.

In 2006, for Digby County, total census families decreased 7.3% to 5,960. Married families decreased by 9.8% while common law families increased 14.6% and lone-parent families increased 21.4%. Lone female parent families were 12.3% of all families while lone male parents were 2.8% of all families.

Compared to Nova Scotia, Digby County has a relatively low immigrant population. In 2006, there were 590 immigrants which are 3.2% of the population compared to 5% immigrants for Nova Scotia. In Digby County, 98.5% of people were Canadian citizens compared to 98.3% for Nova Scotia.

English is the predominant language in Digby County, with 74.7% speaking only English in the home and 69.4% speaking only English at work.

In 2006, the average income for individuals in Digby County was $25,549 a year, compared with the average of $31,795 for Nova Scotia. Families in Digby County had an average income of $52,780, compared with the average of $66,032 for Nova Scotia.

A total of 9.9% of families in Digby County had low income status in 2006, compared with 16.5% in 1996. In Nova Scotia, 10.3% of families had low income status in 2006, compared with 16% in 1996.

Shelburne[33]

Based on the 2006 Census of Population, Shelburne County has a population of 15,540 which is 8.6% lower than in 1996. In 2006, 22.8% of the population was under the age of 20 and 16.7% was 65 years or older.

In 2006, for Shelburne County, total census families decreased 8.6% to 5,005. Married families decreased by 11.4% while common law families increased 16.2% and lone-parent families increased 28.6%. Lone female parent families were 12.2% of all families while lone male parents were 3.8% of all families.

Compared to Nova Scotia, Shelburne County has a relatively low immigrant population. In 2006, there were 460 immigrants which are 3% of the population compared to 5%

[32] http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1203

[33] http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1201

immigrants for Nova Scotia. In Shelburne County, 98.8% of people were Canadian citizens compared to 98.3% for Nova Scotia.

English is the predominant language in Shelburne County, with 99.2% speaking only English in the home and 98.4% speaking only English at work.

In 2006, the average income for individuals in Shelburne County was $26,770 a year, compared with the average of $31,795 for Nova Scotia. Families in Shelburne County had an average income of $54,017, compared with the average of $66,032 for Nova Scotia.

A total of 9.2% of families in Shelburne County had low income status in 2006, compared with 13.1% in 1996. In Nova Scotia, 10.3% of families had low income status in 2006, compared with 16% in 1996.

Leeside Transition House

Richmond County[34]

Based on the 2006 Census of Population, Richmond County has a population of 9,740 which is 11.6% lower than in 1996. In 2006, 21.6% of the population was under the age of 20 and 19.7% was 65 years or older.

In 2006, for Richmond County, total census families decreased 11.6% to 3,115. Married families decreased by 7.8% while common law families increased 1.9% and lone-parent families increased 0.0%. Lone female parent families were 12.4% of all families while lone male parents were 3.2% of all families.

Compared to Nova Scotia, Richmond County has a relatively low immigrant population. In 2006, there were 240 immigrants which are 2.5% of the population compared to 5% immigrants for Nova Scotia. In Richmond County, 97.7% of people were Canadian citizens compared to 98.3% for Nova Scotia. 88.3% of Richmond County's population was born in the province of their residence.

English is the predominant language in Richmond County, with 91.7% speaking only English in the home and 85.6% speaking only English at work.

In 2006, the average income for individuals in Richmond County was $27,409 a year, compared with the average of $31,795 for Nova Scotia. Families in Richmond County had an average income of $54,276, compared with the average of $66,032 for Nova Scotia.

A total of 7.6% of families in Richmond County had low income status in 2006, compared with 16% in 1996. In Nova Scotia, 10.3% of families had low income status in 2006, compared with 16% in 1996.

[34] http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1216

The employment rate for Richmond County residents aged 25 and over increased by 4.6 percentage points to 44.4% between 1996 and 2006 and there were 280 more employed workers. Nova Scotia's employment rate experienced an increase by 3.6 percentage points to 58% between 1996 and 2006 and there were 46,050 more employed workers, during this same period.

Inverness County[35]

Based on the 2006 Census of Population, Inverness County has a population of 19,035 which is 9.0% lower than in 1996. In 2006, 23.9% of the population was under the age of 20 and 17.2% was 65 years or older.

In 2006, for Inverness County, total census families decreased 9.0% to 5,500. Married families decreased by 4.8% while common law families increased 29.3% and lone-parent families increased 8.4%. Lone female parent families were 14.0% of all families while lone male parents were 2.6% of all families.

Compared to Nova Scotia, Inverness County has a relatively low immigrant population. In 2006, there were 610 immigrants which are 3.3% of the population compared to 5% immigrants for Nova Scotia.

English is the predominant language in Inverness County, with 87.6% speaking only English in the home and 86.5% speaking only English at work.

In 2006, the average income for individuals in Inverness County was $28,878 a year, compared with the average of $31,795 for Nova Scotia. Families in Inverness County had an average income of $61,666, compared with the average of $66,032 for Nova Scotia.

A total of 5.9% of families in Inverness County had low income status in 2006, compared with 12.5% in 1996. In Nova Scotia, 10.3% of families had low income status in 2006, compared with 16% in 1996.

[35] http://www.gov.ns.ca/finance/communitycounts/profiles/community/default.asp?gnew=&table=&acctype=0&chartid=&mapid=&dcol=&sub=&ptype=geo&tid=&gview=1&glevel=cnt&yearid=2006&gnum=cnt1215

D: Literature Scan

Revised Literature Review for Project:

Positive Mental Health Outcomes for Women Experiencing Violence and Abuse in Rural and Remote Areas

Note:

This literature review was originally completed by Janet Allen, Atlantic Centre of Excellence for Women's Health, entitled A Literature Review for Service Delivery Model for Women Experiencing Violence and Abuse in Nova Scotia: Intersections of Mental Health, Poverty, and Substance Use (July 2008) Ms. Allen's Review has been edited and adapted by Pamela Harrison (May 2011)

Introduction

How communities respond to the issue of family violence against women can be directly linked to survivors' health and safety (Allen, Bybee & Sullivan, 2004). Shelters and transition houses continue to be the primary community service providers to this population of women. These services tend to be understaffed and under-funded and therefore become overwhelmed by the increasing demand to respond to a wide range of needs related to women's experiences of violence. This review discusses women's service needs regarding their experiences of violence in their intimate relationships and patterns of service use locally, nationally, and internationally. Service providers are particularly concerned with the provision of positive mental health outcomes for women experiencing violence and abuse, in rural and remote areas. This concern also means addressing potential barriers women may experience in accessing services related to race, ethnicity and culture, Aboriginal status, immigration status, ability, sexual orientation, and geography.

Service Needs & Use among Women Experiencing Violence

Locally – In Nova Scotia

While urban shelters in NS are at or over capacity, women are less likely to access services as a shelter resident in the rural and remote areas of the province. In the two years that the Transition House Association of Nova Scotia has been tracking the number of women accessing services on an outreach basis (women accessing appointments, group activities, phone counselling, court accompaniment, safety planning and information/referrals) these methods of accessing services have increased. In particular it is important to note that 66% of women who accessed outreach services had never been a resident of a transition house. Barriers identified in using residential services in rural and remote areas include transportation, lack of confidentiality of shelter locations, lack of personal confidentiality in small communities, women's access to their jobs, which might be some distance from the shelter, as might be the schools their children attend (THANS Statistical Overview: Homeless Individuals and Families Information System[HIFIS]2008-2010.)

Nationally – Across Canada

Even less women are reporting incidents of Intimate partner violence to police than in 2004, and those that do report are more likely to be within the ages of 24 to 35. Reporting of serious incidents of violence are comparable to 2004, and close to one in five Canadians report that they experienced some form of emotional or financial abuse in their intimate relationship (Family Violence in Canada: A Statistical Profile, Statistics Canada, Catalogue no. 85-224-X, 2010.) Canadian data suggests that the most commonly employed help-seeking activity for women dealing with violence is telling friends and family, however women victimized by a spousal offender are more likely to also engage in more substantial help-seeking strategies that include disclosure to

formalized sources of support (Kaukinen, 2002). Furthermore, as incidents of violence increase in severity, so does the likelihood that women will report to various service providers including police, medical professionals, and social service agencies (Kaukinen, 2002). In comparing data from two wide scale Canadian telephone surveys, the 1993 Violence Against Women Survey and the 1999 General Social Survey, Du Mont, Forte, Cohen, Hyman and Romans (2005) found that rates of help-seeking had increased in the six intervening years, yet there were still a large number of Canadian women not receiving structured supports around violent relationships. Even with a slight increase in service use as of 1999, women still infrequently utilized community-based domestic violence services with 17% accessing crisis centers or hotlines, 15% accessing community or family centers, 11% accessing shelters or transition houses, and 11% accessing women's centers (Du Mont et al., 2005).

Internationally

In their population study of random telephone sampling in South Carolina, Coker, Derrick, Lumpkin, Aldrich, and Oldendick (2000) found that intimate partner violence is common and that most victims do not receive services to address these experiences. They note several factors that influence help-seeking behaviour; that victims must perceive themselves in need of services, that there are services available in their area, and that these services will be helpful and affordable (Coker et al., 2000). Of those women that do reach out, the majority turn to family and friends in regard to their experiences of violence (Coker et al., 2000; Du Mont et al., 2005; Short et al., 2000; West, Cantor & Jasinski, 1998). Allen et al. (2004) examined the efficacy of advocacy services as part of service delivery for battered women in the American Midwest. They advocated for individualized, comprehensive, flexible and creative advocacy service provision to meet survivors' self-defined needs and wants. In their sample, these needs ranged from acquiring basic needs such as housing and material goods to long-term life goals and planning through increasing level of education or exploring employment options. Regarding the need for long term support, Wuest and Merritt-Gray (1999) point out that "although helper support during the initial leaving process is vital, the struggle to sustain the separation and not go back requires even more support" (pp. 110-111).

Hague and Mullender (2006) looked at the extent to which the voices and views of domestic violence survivor's direct service provision in the United Kingdom and found that user involvement in the management and decision making of shelter and support services is decreasing. The authors attribute this shift away from participatory service provision to the trend toward professionalization and also demands of funders. Although 90% of shelter organizations interviewed in their research regularly consult domestic violence survivors directly about the provision of services, very few service users indicated they perceived they had any real power to influence the agency (Hague & Mullender, 2006). Hague and Mullender advocate for established procedures to involve service

users being mindful that an overly bureaucratic approach tends to alienate participation and that the confidentiality and safety needs of women involved are paramount.

Barriers to Accessing Service

Women experiencing intimate partner violence report numerous barriers to using services. These barriers are often intensified for women marginalized by race, immigration status, ability, sexual orientation, and geography, each of which is discussed in the following sections. More generally, some common reasons given by victims for not accessing services include not wanting or needing help (Dal Grande, Hickling, Taylor & Woolacott, 2003; Du Mont et al., 2005; Fugate, Landis, Riordan, Naureckas & Engel, 2005; Gondolf, 1998), unaware of any health related services that dealt with the issue (Dal Grande et al., 2003; Fugate et al., 2005), the violent incident was perceived as too minor (Dal Grande et al., 2003; Fugate et al., 2005), too much time had elapsed since the violent incident (Dal Grande et al., 2003), fears about losing custody of their children (De Voe & Smith, 2003; Fugate et al., 2005; Peckover, 2003), and lack of trust in the medical system (Rodriquez, Quiroga & Bauer, 1996). Fugate et al. add that prohibitive costs, lack of privacy, time constraints, self-reliance, feelings of shame and embarrassment, safety concerns, and lack of trust in the legal system are also reasons women give for not seeking service around intimate partner violence (Fugate et al., 2005).

Sullivan and Rumptz (1994) report that Black women tend to stay in shelters longer than white women and attribute this pattern to the institutionalized racism faced by Black women when applying for housing, income assistance, or employment training. Grossman, Hinkley, Kawalski and Margrave (2005) point out that in rural areas where these social services are harder to come by and more spread out, women of color are doubly disadvantaged. In terms of geographical and physical isolation, Grossman et al. (2005) note that “Black rural victims had almost double the need of their white rural counterparts for transportation and were almost three times more likely than their Black urban counterparts to need it” (p. 76).

Aboriginal Status

As Maracle (as cited in Green, 2007) points out, “east, south, west and north must all develop their own process of healing – as must urban areas and reserve” (p. 1). It is therefore important to consider regional context when discussing violence in Aboriginal communities. Individual communities and organizations in the Maritimes have developed some initiatives and supports for Aboriginal women experiencing partner violence such as the programs and supports provided by the Mi’kmaq First Nation communities of Nova Scotia (Green, 2007). Their services include shelters for women and children, outreach for men, a crisis telephone service, group and individual counselling and community education for Aboriginal people in Nova Scotia (Green, 2007). Funding for the Nova Scotia Native Women’s Association has also been secured, in part, to organize a

conference on the issue of family violence (Department of Canadian Heritage, 2005). In the past year, Mi'kmaw Family and Children's Services have initiated an Aboriginal Men's intervention Program in Eskasoni (Boyd, Debbie, 2010).

In Canada as a whole, it is clear that family violence against women is disproportionately high in Aboriginal communities (Brownridge, 2003; Campbell, 2007). Ogrodnik (2007) reported that Aboriginal women were three times more likely to be victims of spousal violence than were non-Aboriginal women while Brownridge (2008) found the rate to be closer to four times greater for Aboriginal women in samples taken in 1999 and 2004. Furthermore, Aboriginal women were more likely to experience more severe abuse (Brownridge, 2003; Ogrodnik, 2007) and for longer periods of time (Brownridge, 2003).

Immigrant Status

There is a considerable body of North American literature respecting violence experienced by immigrant women. There is much discussion around the cultural context of domestic violence work (Dasgupta, 2005; Jiwani, 2001; Latta & Goodman, 2005; Raj & Silverman, 2002; Sharma, 2001) as well as patterns of violence and service delivery (Hyman, Forte, Du Mont, Romans & Cohen, 2006a, 2006b; Latta & Goodman, 2005; MacLeod & Shin, 1992). Many researchers have explored violence in particular immigrant communities such as South Asian (Abraham, 2005; Dosanjh, Deo & Sidhu, 1994; Hurwitz, Gupta, Liu, Silverman & Raj, 2006; Raj & Silverman, 2003), Portugese (Barata, McNally, Sales & Stewart, 2005), Vietnamese (Bui, 2003; Bui & Morash, 1999; Morash, Bui, Zhang & Holtfreter, 2007), Chinese (Hicks, 2006), Haitian (Latta & Goodman, 2005), and Ethiopian (Sullivan, Senturia, Negash, Shio-Thornton & Giday, 2005). Among abused immigrant women, the most common reasons given for not using services are social isolation, language barriers, discrimination, and fears of deportation (Abu-Ras, 2003; Barata et al., 2005; Bauer, Rodriquez, Quiroga, & Flores-Oritz, 2000; Du Mont et al., 2005; Fugate et al., 2005).

Ability

Women with disabilities specify issues of violence as their most important priority with regard to research and health (Curry, Hassouneh-Phillips & Johnston-Silverberg, 2001). Predictably, research demonstrates that violence against women with disabilities is most commonly perpetrated by an intimate partner (Milberger et al., 2003; Ridington, 1989; Young, Nosek, Howland, Chanpong & Rintala, 1997). Several studies confirm that rates of intimate partner violence are higher for Canadian women with disabilities than women without disabilities (Brownridge, 2006; Brownridge, Ristock & Hiebert-Murphy, 2008; Cohen, Forte, Du Mont, Hyman & Romans, 2005). Women with disabilities may also experience unique types of violence such as removal of an accessibility device, withholding medication, and threatening institutionalization (Gilson, DePoy & Cramer, 2001; McFarlane et al., 2001).

According to Brownridge's (2006) study of Canadian women living in a marital or common law union, women with disabilities had 40% greater odds of experiencing violence in their intimate relationships over five years preceding the interviews, and these women appeared to be at particular risk for severe violence. Brownridge also found that "male partners of women with disabilities were about 2.5 times more likely to behave in a patriarchal dominating manner and about 1.5 times more likely to engage in sexually proprietary behaviors than were male partners of women without disabilities" (p. 818).

Sexual Orientation

It is difficult to establish accurate prevalence rates for intimate partner violence for lesbian and bisexual women (Chesley, MacAuley & Ristock, 1998). Additionally, Scherzer (1998) challenges using purely quantitative data to determine incidence rates of violence in lesbian relationships and maintains that studying the nuances of power dynamics requires qualitative data. Ristock attributes the invisibility of violence in lesbian relationships to a "strong concern that drawing attention to this form of violence will undermine feminist efforts that have named male violence against women as a significant issue in our culture" (as cited in Ristock, 2003, p. 329). She further advocates for developing a new contextual understanding of violence in lesbian relationships that does not rely on heterosexual gender-based frameworks (Ristock, 1994).

Poverty & Homelessness

Poverty severely limits women's options in terms of income and employment (Carillo, 1992), housing (Fugate et al., 2005; Miller & Du Mont, 2000), and education – all of which impact women's experiences of abuse and resources for seeking service and support. Women may be economically dependent on their abusive male partners for survival and dynamics of control and domination in violent relationships prevent many abused women from working outside the home or pursuing additional education. Poverty is particularly relevant when considering partner abuse in rural areas. Women's economic status can be negatively affected by separation and divorce from an abusive partner (Davis, 1999) and small communities are often plagued by joblessness (DeKeseredy & Joseph, 2006). Housing, education, and employment options are often severely limited for women in rural and/or remote areas (Feyen, 1989; Grossman et al., 2005; Logan et al., 2003).

Geography: Rural and Remote Area Barriers

There is considerable evidence to support that women experiencing family violence in rural areas face additional barriers to accessing service and receiving support (Feyen, 1989; Grossman, Hinkley, Kawalski & Margrave, 2005; Hilbert & Krishnan, 2000; Tice, 1990; Websdale & Johnson, 1998). Rural areas tend to be under-serviced (Jiwani, Kachuck & Moore, 1998) and women may not necessarily be aware of services even when they are available (Martz & Bryson Saraurer, 2000). Logan, Walker,

Cole, Ratliff and Leukefeld (2003) suggest that different services such as outreach are needed in rural areas that may not be required in urban centers. Women in rural and/or remote communities experience considerable geographical and social isolation compounded by inadequate access to transportation (Feyen, 1989; Grossman et al., 2005; Lewis, 2003) and telephone services (Websdale, 1998).

A further barrier for rural women survivors of family violence is what Websdale and Johnson (1998) refer to as a "rural patriarchy". This term encompasses the conservatism and widespread acceptance of woman abuse that characterizes many rural environments (Krishnan, Hilbert & Pase, 2001; Lewis, 2003; Navin, Stockum & Campbell-Ruggaard, 1993). While the cultural norms of self-reliance and family/group loyalty are present in dominant North American culture as a whole, the ingrained social attitude that "what happens in the home, stays in the home" can be particularly powerful in rural communities. The geographic and social isolation of rural areas together with the intimacy of community bonds can perpetuate a lack of anonymity that can make women who have experienced abuse reluctant to access medical and/or social services (Websdale & Johnson, 1998). Therefore, confidentiality is an important concern for women accessing services for family violence in rural areas (Gill & Thériault, 2002; Hornesty & Doherty, 2001). Whereas much of the intimate partner violence data in the literature is drawn from clinical points of contact, i.e. shelters, hospital emergency rooms, counseling programs, substance abuse programs, in rural areas, these services tend to be sparsely provided. Data that does attempt to look at women who have not accessed these services involves random sampling, often using telephone survey methods and selection techniques leaving out populations who do not have consistent telephone service such as those living in poverty and/or in rural and remote areas. Logan et al. (2003) used a protective order sample as a way of accessing both women who used services available and those who did not.

Mental Health as an Intersecting Issue in Service Provision

In Rural and Remote Areas

Coker et al. (2000) found that among women who experienced physical intimate partner violence, almost half (45.5%) received mental health services (counseling/therapy) while only 11% sought the services of domestic violence shelters, data which is consistent with numbers found in other studies (Fugate et al., 2005; Gondolf, 1998; West, Cantor & Jasinski, 1998). Du Mont et al. (2005) name clinical depression, anxiety disorders, substance abuse problems, and eating disorders as common psychological effects of intimate partner violence (Coker & Davis et al., 2002; Coker & Smith et al., 2002; Golding, 1999; Koss, 1990; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). While Post Traumatic Stress Disorder has been recognized for some time, only recently have therapists begun to recognize and address complex in female clients with a history of chronic abuse (Haskell, 2003.)

post- traumatic stress responses For some women, the severity and/or cumulative effects of trauma and violence are so great that they attempt to or take their own lives (Carillo, 1992; Coker & Smith et al., 2002; Golding, 1999). Regarding mental health and specific populations, Logan et al. (2003) found that “health and mental health problems were much more severe among rural women than among urban women” (p. 90), which is consistent with the literature noting elevated levels of need respecting health services in rural areas.

E: 2008-2010 THANS Statistics

Nova Scotia's (THAN's) nine off-reserve shelters have a total of 132 beds.

HIFIS Statistics	*2008*	*2009*	*2010*
# of Unique Individuals	971	932	969
# of Admissions	1112	1109	1188
Total # of shelter Nights	22,824	21,172	20,665
Average length of Stay	18	20	21
# of Moms	337	317	315
# of children	368	321	354

Types of Services*	**Percentage**		
	2008	2009	2010
Information & Referrals	4	4	35
Counselling	63	71	33
Advocacy	14	7	18
Criminal Justice Services	6	3	4
Support Groups	2	3	4
Transportation	3	9	3
Childcare	8	3	3

**these percentages reflect only those shelters who provided goods and services information*

Reason for Service**	2008	2009	2010
Partner Abuse, Psychological	52%	40%	49%
Partner Abuse, Physical	29%	33%	30%
Partner Abuse, Sexual	5%	3%	7%
Relationship Breakdown	18%	24%	14%

***Only one "reason for service" is recorded, though most service users experience more than one type of abuse*

Reasons for Discharge	2008	2009	2010
	By Percentage		
To Family and Friends	31	26	29
Housed* **	21	30	27
Back to Abusive Partner	26	20	21
Another Shelter	9	3	7
Left Area	4	8	6
Hospital/Treatment	3	1	3
Suspended/Barred	3	4	3
Other	3	8	4

*** ****Housed in private market, affordable, supportive or supported housing***

The Majority of Women and Children stay at a THANS shelter only once:

2008			2009			2010		
Residents	**Stays**	**%**	**Residents**	**Stays**	**%**	**Residents**	**Stays**	**%**
807	1	87	820	1	87	832	1	86
92	2	10	94	2	10	102	2	11
18	3	2	18	3	2	20	3	2
15	4+	1	10	4+	1	15	4 +	1

Three Year Age Breakdowns for Residents:

Age of							
	16-19	**20-29**	**30-39**	**40-49**	**50-59**	**60 +**	**TOTALS:**
WOMEN	137	530	443	461	176	82	1829
Other*	0	0	0	0	0	0	
CHILDREN	**1-2**	**3-4**	**5-7**	**8-12**	**13-16**	**16 +**	
Girls	135	81	93	126	61	38	534
Boys	159	93	83	100	54	20	509
						TOTAL:	**2872**

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