

Summary of Research Report

Mental Health in Québec: Women's Community Organizations at a Crossroads



*Réseau québécois d'action
pour la santé des femmes*

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“ ...we must denounce the deterioration
of our social fabric.

Community organizations
shouldn't have to shoulder the burden alone.

It's not our job to compensate
for this state of deterioration...
brought about by neoliberal policies... ”

Worker in a women's group

SUMMARY



INTRODUCTION

The study *Santé mentale au Québec : les organismes communautaires de femmes à la croisée des chemins* (Mental Health in Québec: Women's Community Organizations at a Crossroads) was undertaken in 2010 in a context of dwindling financial resources in the public health system, a decentralized health system, and increasing medicalization of social problems. The Réseau québécois d'action pour la santé des femmes (RQASF) wanted to understand the consequences on its member groups of the health reform and the growing number of social and mental health problems faced by their participants.

Of the 92 groups eligible to take part in the research, 75 of them agreed to participate, all women's community organizations from across Québec that work directly with women. Our analysis is drawn from the findings of a questionnaire that we mailed to the groups (and that were returned to us with abundant comments and explanations), interviews and discussions with the 9-member research advisory committee.

This document is a condensed version of the final research report. It presents the main findings concerning the workers' perspective on mental health, their participants' living conditions and difficulties obtaining health services, and last, their views on the impacts these problems are having on their groups, missions, internal operations and staff. It also presents a number of critical issues for the women's health movement in Québec. These are listed in the conclusion. A more detailed discussion of the historical and political context of the health reform, the communalization of services and the medicalization of social problems, as well as a presentation of the research approach and methodology, are included in the full research report. The full version also contains numerous comments from the front-line women workers who participated in the study.

Women's mental health and living conditions and the inaccessibility of the health system

Deteriorating living conditions

Growing **impoverishment** leads to living conditions of extreme hardship, pushing increasing numbers of women to knock on the doors of women's community groups. In a period characterized by a crisis in housing, many women working in women's organizations witness the psychological distress of group participants stemming from their **inability to obtain adequate housing**.

Workers have also observed a rise in the number of mental health problems linked to work, either due to **precarious or discriminatory working conditions or lack of employment**. The absence of a social network, the difficulty of balancing work and family and discrimination make the job search particularly arduous.

In over half the groups, the majority of women participants receive social assistance, in other words, are living below the poverty line. Lack of income brings more women to the groups because they simply do not have enough to eat. Some women are also forced to accept the unacceptable out of **financial insecurity**: staying at a job where they are being harassed or in relationships where they are being abused. Last, newcomers experience extreme economic hardship while waiting for husbands who are still in their home countries.

Poverty and the spectrum of discrimination and problems associated with it, often produce **social isolation**. In the regions outside urban areas, lesbians suffer from isolation related to their geographic location, financial situation and sexual identity, all of which combine to increase their risk of psychological distress. Isolation, discrimination and a **lack of adapted services** can

undermine the mental health of women with disabilities. The same is true of women who have recently immigrated to Québec.

An economic context of deepening inequality is fertile ground for all forms of **violence**. Women's groups have observed an increase in violence against older women and cases of violence suffered in childhood (women who have remained silent for years and are now experiencing the consequences of childhood traumas). They also see young women who numb themselves with drugs. Last, because they are the target of several forms of discrimination, some women are victims of **multiple forms of violence**. This is often true of homeless women, whose numbers are on the rise. Violence exacerbates psychological distress.

The phenomenon of sex trafficking is also of great concern. It affects not only many women from outside Québec, but also women who were born here, including significant numbers of Aboriginal women. Workers also reported that Aboriginal women are suffering from increased violence and that their living conditions are deteriorating. Furthermore, although over 80% of disabled women are victims of sexual violence, they are often reluctant to report their attacker, who is most often someone close to them or a social or health worker.

Inaccessible services

Public services are insufficient, complain workers in women's groups (too few family physicians, who frequently serve as the gateway to mental health services). When participants are referred to the public network for psychological assistance, they sometimes face waiting lists of several months, during which times their condition tends to worsen.

Women participants also pay the costs of a **lack of mental health community housing resources**, because, despite the clear need for these services, according to many workers, such agencies are closing. Housing for homeless women, for example,

is in desperately short supply. Disabled women are confronted with practical obstacles: transition houses are not adapted in 90% of the cases.

The **specific approach**, which has the effect of compartmentalizing individuals, is now dominant in the health and social services network. In the public health network, people are rarely treated holistically, as whole persons; rather, they are diagnosed and then referred to a specialized service or, frequently, are **rapidly and inadequately medicated**.

Many women working in women's organizations denounce this approach. In the case of women who are victims of domestic violence, they particularly deplore the medical approach that too often is restricted to a consideration of symptoms; they insist on the need to examine **the woman's whole history** and understand the impacts of violence (weak self-esteem, depression, post-traumatic shock, suicidal feelings, etc.). The failure to take women's experience of violence into account can have the effect of maintaining women in their condition of psychological distress.

A direct consequence of the lack of resources in the health network is the phenomenon of **dumping**. This consists of the near systematic referral of individuals to community organizations when they should be receiving medical care and other health services. **Dumping adds to the problems experienced by some women participants in the groups**. Women knock on the doors of women's organizations after being shunted from one resource to the next and **before receiving any of the health care they require**; they are discouraged and at the end of their rope.

Impacts on groups of an inaccessible health system

Groups' missions are threatened

According to the research advisory committee, most women's groups **try not to be diverted** from their principal mission; however, it is very difficult to continue making it a priority. Many different factors are involved here: dumping, rising mental health needs, the need for individual follow-up and the high numbers of participants whose essential needs are not being met.

These groups are working with women who should not have been referred to them (**dumping**) and who are mainly arriving from the health and social services network. Women who used to participate in alternative mental health resources, which are now closed, are also now coming to local women's organizations. Women's groups have to deal with new issues that are far beyond the scope of their missions. **This erosion of the health network and the closing of different mental health resources are the result of political choices.**

The **increase in mental health-related requests** is now forcing women's groups to make decisions about acquiring specialized knowledge. Groups are wondering whether it is realistic to train workers on what seems to be a nearly endless list of disorders. They fear this will lead to a more curative than preventive approach, at the expense of a holistic approach. Another agonizing dilemma: it is very hard to refuse a woman with serious problems, including psychiatric disorders, knowing that the group might be her last resort. But how can they provide her with the assistance she needs without neglecting their principal mission?

The growing complexity of women's problems has also raised the **question of individual counselling**, resulting in major debates in some groups. The expanded role of individual counselling also compromises the collective approach of groups that prioritize group action and a "home environment" set-up.

Last, the obligation to address women's **survival needs** more than in the past is encroaching on health prevention and promotion activities.

Disruption of groups' internal operations

At the administrative level, it is a significant challenge for groups to handle participants with unpredictable behaviours.

Many workers reported difficulties experienced by their teams in dealing with the **crises** of certain participants (panic attacks, outbursts linked to prescription or illicit drug use, etc.).

Rising numbers of participants also creates more potential for risky situations. The groups affirm that some workers are sometimes **frightened** when they are intervening with women who suffer mental health problems. In many groups, especially those that offer shelter, workers are frightened more often than before for their own physical safety and that of participants.

The consequences of constant exposure to high-risk situations are serious. Some workers suffer from hypervigilance (being constantly on the lookout, constantly fearing attack), which can even affect their private relationships.

Drugs are sometimes necessary to treat certain health problems, but **over-prescription** is harmful, report workers. Women's ability to concentrate is altered. Some women do not understand what is happening or are somnolent and this makes it hard to facilitate group activities. Another **side effect of the drugs** is the inhibition of emotions; workers then have trouble communicating effectively with women participants and encouraging them

to talk about their pain. The unpredictable behaviour of some medicated women can also interfere with group process.

Last, medication is linked to a **diagnosis**, and there is a tendency for this to become women's **actual identity**. Yet, the goal of women who work in women's organizations is women's personal empowerment and positive reinforcement rather than their illness and symptoms.

Groups that provide individual counselling must decide what limits to set in assisting women participants. How do they prevent situations in which a woman is forced to wait or feel neglected because they are giving more time to another woman? These questions and others like them engender tension and stress in the groups. An integral component of the mission of women's organizations is **the promotion of women's rights and collective mobilization and action** to sensitize the public and decision-makers so they will act on health determinants. Unfortunately, these activities are now often **abandoned** due to the daily reality of many women's groups. Many workers spoke about the paradoxical situation in which the need for political action and lobbying seems greater than ever before but they have less and less time in which to do that kind of work.

Staff is overloaded

More participants, more complexity and more work: this sums up the situation. Numerous workers feel overwhelmed by the amount of work that must be done with participants who suffer from mental health problems. Yet, work overload is not just due to a higher number of women in distress; it can also be explained by the complexity of the tasks that must be accomplished.

The time required to **demystify women's problems** has multiplied tenfold: the deterioration of living conditions, increase in female homelessness and substance abuse (including overconsumption of prescription drugs) have necessarily changed

the counselling process. Similarly, workers repeatedly mentioned that they are spending more time on **referrals** than before. Women with serious mental health problems must be referred to other agencies. The time spent **accompanying women** who need treatment in the health system has also increased, in large part because of the inaccessibility of the health system.

Furthermore, some groups must spend more time than in the past accompanying women to court or **taking legal steps** on their behalf. The legal process can take a very long time and involves numerous obstacles for women.

Structural adjustments must be made **due to the medicated state of women participants**. Transition house workers have had to set up systems for managing their residents' drugs. This situation, and the need to **do research** in order to understand the nature of the drug and its side effects and be in a position to alert women to the danger of drug overdoses, demands time, much vigilance and involves certain risks to the employees who assume these responsibilities.

Sense of impotence, under-appreciation, frustration and burnout... We also examined the effects of this situation on the health of the workers themselves and groups' initiatives for dealing with this.

Workers mostly feel impotent due to their inability to adequately assist some participants. This contributes to the sense that their work has lost its meaning and discouragement about their effectiveness. A number of groups have moved away from the traditional feminist intervention framework and entered into service agreements that oblige them to take a more individualistic approach. But is this always a choice?

Moreover, as women's problems have increased, the risk of workers' excessive emotional investment has also risen. "Compassion fatigue" and "vicarious syndrome" (striking changes in a worker who develops an empathetic relationship with a survivor and is

exposed to their experiences) can have a devastating physical and psychological impact.

Numerous workers are also plagued by chronic stress, burnout, depression, physical problems, etc. Many groups are witnessing an upsurge in sick leaves and staff turnover. Some workers are going so far as to question their group's survival.

Many teams set aside time to meet, decompress and share information. This time is very beneficial to workers' health. Groups also attempt to prevent burnout by setting up clinical supervision or providing outside psychological support. However, the majority do not have the means to offer this type of assistance.

Conclusion

The living conditions of the women who participate in women's community organizations are deteriorating, and access to social and health services is increasingly restricted, resulting in unacceptable situations that undermine the health of the most disadvantaged women. More and more women with multiple problems are seeking assistance from community organizations.

The intensification of women's social and mental health problems, combined with the undue pressure communalization has exerted on groups and the internal tensions to which this has given rise, contribute to the degradation of workers' health.

Moreover, **the questions confronting most teams on a daily basis and internal friction are of great concern.** To what extent can workers invest themselves in particular women without negative consequences on other participants and the smooth functioning of the group? How should workers respond to heavily medicated women whose attitude undermines the group dynamic? Should groups increase the time they spend on individual counselling, even if this runs counter to their mission? Should they train workers so they can deal with several specific types of problems that are unrelated to a health promotion approach? Last, is it desirable to put aside a community-based approach because of the pressing needs of some participants? These are the challenging questions confronting women's organizations right now.

It is crucial that the causes of these problems and the contradictions facing workers be addressed. If women's living conditions are to be improved, social assistance must be increased and measures put in place to ensure their access to decent and affordable housing. Another imperative is a mental health policy that is clearly committed to the well-being of those in need, including numerous women of all origins and social conditions. Countering the harmful effects of the over-prescription of drugs should be another governmental priority.

We must also, of course, clarify the respective roles of women's groups and the health network with a view to eliminating dumping, restoring to the health system its health promotion role, and allowing community organizations the freedom to define their own mission in this respect. Allocating financial resources to women's organizations to ensure their survival, better working conditions for their employees and the possibility of fulfilling their true missions is also of key importance. Their innovative practices provide a distinct and complementary option to the health system's curative and standardized approach. These groups are unique spaces brimming with humanity that foster a sense of belonging and mutual aid.

The women's health movement is at a crossroads. Employees in the health network and the population at large are making the same observations as the workers in women's community organizations. In 2009, the World Health Organization's Commission on Social Determinants of Health toured the world and wherever they went, the same needs were being expressed. They issued a heartfelt appeal to governments to take urgent action on human health. The women's health movement in Québec, of which RQASF is a member, is ready and willing!

HIGHLIGHTS



Participation in the research: 81% of eligible member groups (75 groups/92), all of them women's community organizations that work directly with women in different regions across Québec.

Six key observations can be drawn from the research:

1 Socioeconomic conditions of women participating in women's community organizations are deteriorating throughout Québec, undermining their mental health. Workers in these groups observe:

- increasingly perceptible women's impoverishment (79% of groups)
- deterioration of the social fabric manifested by **increased:**
 - social isolation (71 % of groups)
 - financial insecurity (56% of groups)
 - indebtedness and financial difficulties (70% of groups)
 - food insecurity (63% of groups)
 - marital problems (63% of groups)
 - domestic and family violence (51% of groups)
 - problems linked to body image (51% of groups)
 - discrimination (34% of groups)
 - homelessness (33% of groups)
- shortages in social housing
- participants' needs changing in recent years (72% of groups)

2 The mental health of women participating in women's community organizations is deteriorating throughout Québec. Workers observe:

- a higher rate of participants suffering from mental health problems (66% of groups)
- an intensification of mental health problems (75% of groups), because more women:
 - suffer from stress and anxiety (75% of groups)
 - suffer from a variety of problems (63% of groups)
 - suffer from psychiatric problems (58% of groups)
 - suffer from dependency on prescription drugs, alcohol and illicit drugs (48% of groups)
 - are coming to the groups in a state of crisis (47% of groups)

3 The accessibility of health and social services is increasingly threatened and the most vulnerable women are paying the highest price. As revealed by:

- the inaccessibility of front-line mental health services (waiting lists of several months for an appointment with a psychologist)
- persisting difficulty in obtaining a family doctor
- the closing of community mental health resources

4 The changing profile of participants and the inaccessibility of public services are confronting women's community organizations with an unprecedented situation:

- 76% of groups are receiving participants who should not have been referred to them (workers use the term 'dumping')
- 59% of groups must refuse certain participants with mental health problems
- 54% of groups observe an increase in the number of participants who appear to require a mental health intervention

5 The accentuation of social and mental health problems affects working conditions in women's community organizations and creates an excessive work load; workers affirm:

- they feel overwhelmed by the work that needs to be done (71% of groups)
- they have trouble dealing with participants' overconsumption of medication/drugs: difficulty facilitating groups, disruption of group process, etc. (60% of groups)
- they are sometimes or often frightened in particular situations (61% of groups)
- they feel impotent due to being unable to adequately assist some participants (82% of groups)

6 This context threatens the mission of the vast majority of women's community organizations, because it affects the nature of their activities; as revealed by:

- an increase in the amount of individual counselling to the detriment of a collective approach
- the abandonment of their community-based approach

RECOMMENDATIONS



GIVEN the representativeness of the Réseau québécois d'action pour la santé des femmes (RQASF) in the women's health movement in Québec

GIVEN the critical situation we have observed in the field, in every region of Québec

GIVEN our position that the government has failed to provide “rapidly accessible” local mental health services

GIVEN that the \$80 million invested to implement the 2005-2010 action plan has not brought about any significant improvements in front-line services

WE RECOMMEND

A] That the Ministère de la Santé et des Services sociaux **acknowledge the deteriorating living conditions and mental health of a growing number of women helped by women's community organizations**, in every region of Québec.

B] That the Ministère de la Santé et des Services sociaux **revisit the biopsychological theoretical framework**¹ it uses to assess the overall issue of mental health in Québec:

1 The biopsychological paradigm deals exclusively with the biological and psychological determinants of health and illness, without taking into account the whole range of social determinants. It is an individualistic approach, focussing on genes and behaviours, that opens the way to discrimination and inequitable treatment. We prefer a biopsychosocial approach in which all factors—psychological, social and biological—are seen as having an impact on health and illness.

take into account the biopsychosocial foundation of mental health, because mental health is not defined simply by the absence of mental illness, but rather by a state of balance and well-being resulting from a complex fabric of interacting biological, psychological and social causes and determinants;

acknowledge in all of its mental health policies the impact of social determinants on health;

acknowledge that to improve the population's mental health, it must ensure the improvement of living conditions, in particular:

- by urging the Ministère de l'Emploi et de la Solidarité sociale to adopt a guaranteed minimum income to provide people with the means to cover their basic needs;
- by urging the Société d'Habitation du Québec, principal housing advisor to the Government of Québec, and the Ministère des Affaires municipales, des Régions et de l'Occupation du territoire, to invest in social, community and cooperative housing.

C] That the Ministère de la Santé et des Services sociaux **incorporate into its 2012-2017 mental health action plan:**

1. Enhanced accessibility of front-line mental health services through:

implementation of centralized access points, as stipulated in the *2005-2010 Mental Health Action Plan*;

allocation of additional resources for the hiring of social work and mental health personnel in the health network, including in the regions;

allocation of additional funds to alternative mental health resources and the creation of such resources in the regions;

training of interdisciplinary teams in the public health network;

training of health network personnel throughout Québec concerning the situation of lesbians and the intercultural approach;

allocation of funding to community organizations seeking to make their facilities more accessible to individuals with reduced mobility;

2. Measures to counter the medicalization of social problems and the resulting excessive medicalization of women, in particular, by:

training health practitioners about the **holistic approach to health**;

revising intervention protocols of health professionals who work with women exhibiting signs of psychological distress;

3. Measures to meet the immediate needs of the most disadvantaged individuals and of women experiencing grave problems, by:

training health network personnel about sexual, conjugal and family violence;

recognizing the autonomy of women's community organizations and their need for additional resources when concluding formal or informal partnership agreements with the health network;

increasing the number of housing units under medical supervision (associated with hospitals) and the number of post-shelter visits with individuals, to prevent homelessness;

allocating funds to increase the number of supervised housing resources;

allocating funds for short-term housing resources for women in crisis.

D] That the Ministère de la Santé et des Services sociaux **plan a stage of consultation** with women's community organizations in the process of drafting, implementing and evaluating its **Action Plan on Mental Health 2012-2017**.

