

Report on Social Action Projects Program

Developed from the Recommendations of
**Bridging the Service Gap
for Sexual Assault and Mental Illness Survivors Report**

Report by

Denise McKinlay, M.S.W, RSW
Lead Researcher, Project Coordinator and Group Facilitator
Carol Kauppi, PhD
Co-investigator and Associate Professor
School of Social Work, Laurentian University
Jamie Caskanette, B.S.W.
Research Assistant and Co-facilitator

Social Action Projects program facilitated by

Denise McKinlay, M.S.W., RSW
Jamie Caskanette, B.S.W.
Caitlin McGowan, S.S.W.

Prepared for and funded by the
Ministry of the Attorney General
“Community Capacity Building” Grant

Prepared by the
Sexual Assault Survivors’ Centre Sarnia-Lambton
118 Victoria Street N., Sarnia Ontario N7T 5W9
Tel.: 519-337-3154
Fax: 519-337-0819
email: sascs1@ebtech.net

Contact the above for additional copies of this report

The report may also be viewed on the web site:
www.bridgingtheservicegap.com

ACKNOWLEDGEMENTS

We would like to thank the team members of the Social Action Project who participated in this pilot program and who gave their time, energy and creative abilities. By sharing their experiences, suggestions and recommendations during and after the program they ensured that the program will be helpful to others. The risk reduction resource all group members designed and developed has the potential to change the lives of children, youth and adults in our community and beyond. We, the facilitators and project team members, would like to acknowledge that the group members taught us that a small group of committed people working together can accomplish miracles.

We gratefully acknowledge the staff and managers of the agencies and organizations who engaged in the consultation process to lend their knowledge and expertise to the study design. Many of these organizations participated in a wide range of activities during the data collection stage.

In particular, we gratefully acknowledge the assistance of the following organizations that assisted with the various phases of the study:

- Bluewater Health Addiction Services
- Sexual Assault/ Domestic Assault Treatment Centre
- Consumers' Survivors Association of Lambton
- Big Sisters
- Probation & Parole Services
- Victim Witness Assistance Program
- Aamjiwnaang First Nation
- North Lambton Community Health Centre
- St. Clair Child & Youth Services
- Canadian Mental Health Association
- Inn of the Good Shepherd & The Haven
- Sarnia Police Services
- Victim Services
- Crown Attorney's Office
- Central United Church

Report on Social Action Projects Program

TABLE OF CONTENTS

INTRODUCTION	1-2
Purpose of the Project	2
DEFINITION OF TERMS	2-3
RATIONALE FOR DEVELOPMENT OF PROGRAM	3
SOCIAL ACTION PROJECTS MODEL	4-5
Environment	5-6
Rationale for Professional Facilitators	6-7
Problem-solving Model	7
Conflict Resolution	7-8
Therapeutic Considerations	8-9
Rationale for a Group Format	9
Rationale for a Mixed Gender Group	9-10
Group Rules	10-11
Group Structure	11
Maintaining Motivation	11-12
Project Selection	12-13
Ethical Considerations	13
Media Launch of Project	13
EVALUATION OF THE PROGRAM	
Program Evaluation Goals	15
Rationale for Qualitative Design	15
Procedure	15
Recruitment of Participants	16
Assessment Interview Screening Criteria	16-17
Participant Sample	17-22
Data Collection	22-24
Data Analysis	24

DISCUSSION OF RESULTS	24-31
CONCLUSIONS	31-32
RECOMMENDATIONS	32-33
REFERENCES	33-34

SOCIAL ACTION PROJECTS PROGRAM

INTRODUCTION

Statement of the Problem

The word “recovery” is prevalent throughout the mental health and sexual abuse/assault literature. The connection between sexual trauma and moderate to severe mental illness has been studied extensively in the extant literature; it is clear that recovery and an improved quality of life are dependent on addressing both these issues. Unfortunately, organizations that have been developed to assist this population often treat the issues of sexual abuse/assault and mental illness discretely. However, if the sexual trauma is treated without addressing the mental health issues or when there is no collaboration with mental health professionals providing service to this population, it is likely that mental illness symptoms will be exacerbated and may lead to periods of intense crisis. If the underlying sexual trauma issues are ignored when treating mental illness symptoms, it is unlikely that lasting progress will be maintained. Although the stated goal for the treatment of both sexual trauma and mental illness revolves around recovery, unless both issues are acknowledge and addressed in the treatment program the goal may not be attained.

Recovery may be defined as taking personal responsibility for symptom management and wellness, having hope and participating in life in a meaningful manner (Noordsy, Torrey, Mueser, Mead, O’Keefe & Fox, 2002). Recovery involves a shift in a person’s self-concept from a primary self-definition as a person with a mental illness or as a sexual trauma victim to a self-concept that includes participation in a meaningful role in society, important interpersonal relationships (friendships, family, romantic/sexual) and a work role or a structured activity such as volunteering (Provencher, Gregg, Mead, Mueser, 2002; Bennet 2003; Townsend & Glasser 2003; Davidson, Stayner, Nickou, Styron, Rowe, Chinman 2001). Integrating the experiences of mental illness and sexual trauma into a positive self-definition is an important part of the recovery process (Olney & Kim 2001). It then becomes vital that a program be developed that addresses the dual issues of sexual trauma and mental illness and that will provide opportunities for this population to participate in meaningful social, societal and interpersonal roles. Many treatment programs that address the issues of mental health and sexual trauma discretely and purport to assist clients towards this goal have been created and implemented. However, as yet, no best practice model has been created (Everett, Adams, Johnson, Kurzawa, Quigly, Wright & Pape 2003).

Little is known about programs that encompass both the domains of mental illness and sexual trauma and their outcomes as they relate to a recovery model. This is an important gap in the literature as people who have experienced sexual trauma and a mental illness represent a large and diverse group in the general population. In Lambton County, one out of five residents (26,000) will experience a mental illness during his or her lifetime (CMHA, 2005). According to national statistics, in Lambton County, one in three

girls/women (21,700) and one in six boys/men (10,313) will be sexually abused or sexually assaulted during their lifetimes (National Clearing House, 2005). As there is a dearth of programs available for this population, it is important that a program based on a recovery model that addresses both issues concurrently and that includes both genders be developed and evaluated to add to the body of knowledge on mental illness and sexual trauma treatment.

PURPOSE OF THE Project

The purpose of this project was to develop and describe the structure and process for the new Social Action Project model and to explore and describe the meaning that group members have placed on their experiences during and after the completion of the pilot Social Action Project program, as well as the development of their project within that program. The literature suggests that recovery for people who have a sexual trauma history and a mental illness is dependent on creating meaning from their experiences and the incorporation of their experiences into a positive self-concept. The Social Action Projects program was designed to provide a format for this population to improve their quality of life by participating in meaningful roles in a program focused on wellness and that is strength-based and collaborative. The development and facilitation of the Social Action Projects program was evaluated to gain information concerning the participants' perspectives and experiences in the group. In addition, the evaluation sought to assess the extent to which they achieved their personal goals and their goals for the resource they developed as a result of their participation in the group.

DEFINITION OF TERMS

The term *serious mental illness* (SMI) will be used in this report to describe the population that, according to provincial policy, has mental health issues severe enough to interfere with their ability to function in society and that requires treatment for the mental illness. The length of time individuals have experienced the problem, the level of dysfunction that has occurred in their lives due to the mental illness and the diagnosis are the three dimensions that are assessed by mental health professionals that qualify a person for a SMI designation. The mental illness diagnoses that are most often considered as serious are schizophrenia, bipolar disorder and some severe forms of depression (Dewa, Rogers, Kates & Goering, 2002).

Childhood sexual abuse (CSA) is defined, for the purpose of this study, as any unwanted and non-consensual sexual behaviours occurring before the age of 16 years. Under the age of 14 years there is no legal consent and any sexual interference by someone constitutes sexual abuse.

Adult sexual assault (ASA) is defined as any unwanted and non-consensual sexual behaviours occurring after the age of 16 years.

For the purposes of this study, *recovery* is defined as a supportive process where persons are encouraged to maximize their lives and achieve a sense of balance and fulfillment. It is a deeply personal and self directed process built on hope, empowerment, meaningful

roles and spirituality. Recovery does not imply that full ability is restored or that no medication is needed (Townsend & Glasser 2003).

SIGNIFICANCE OF THE PROJECT

The results of this project will add to the current knowledge concerning an approach to group treatment for sexual trauma and mental illness. The development of a program model that provides opportunities for meaningful roles for the participants and assists them to move towards recovery may allow other groups to create similar programs for the same or for different populations. It is important that organizational policy makers and funders recognize the importance of such programs so the focus on programming is not just treatment but the provision of opportunities for meaningful roles and experiences.

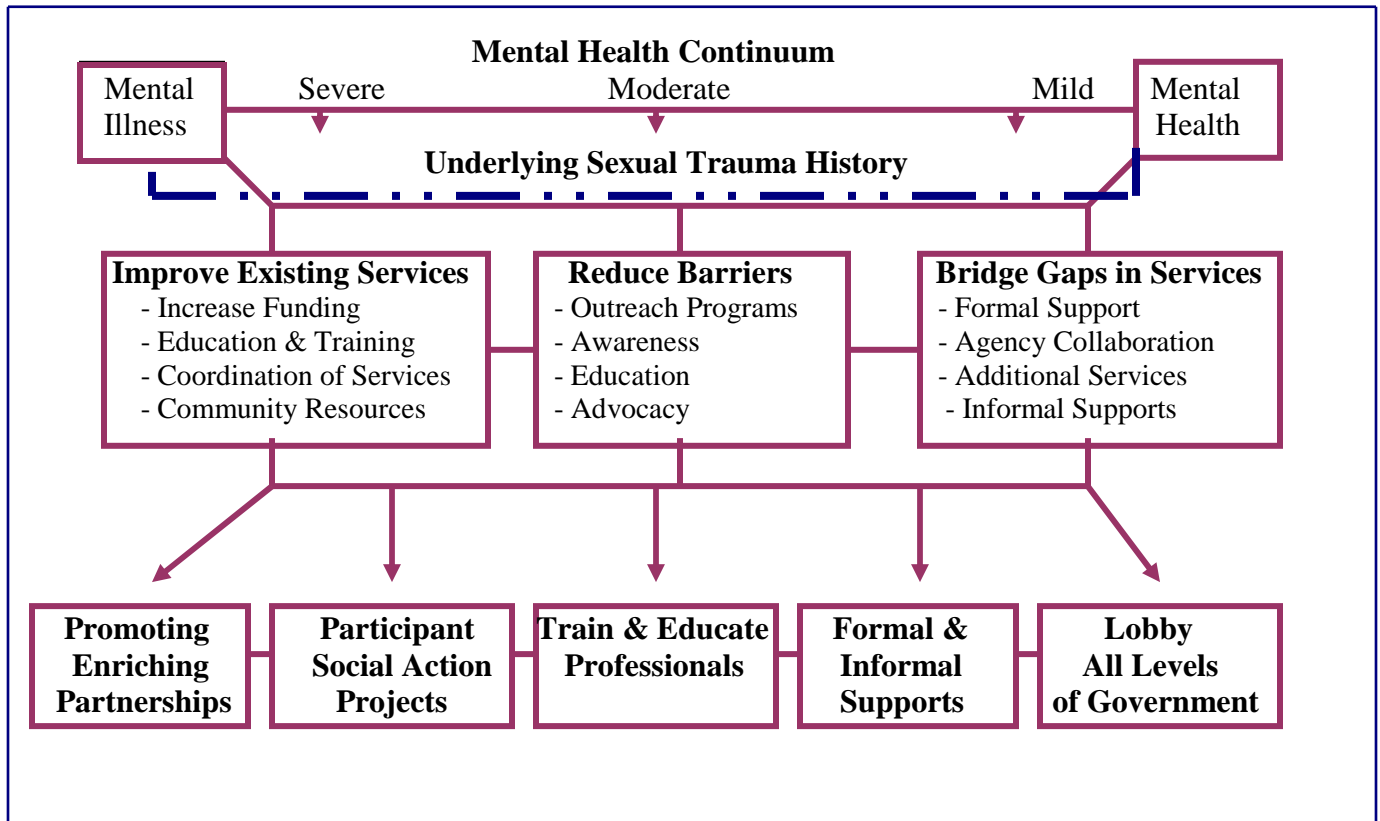
RATIONALE FOR THE DEVELOPMENT OF THIS PROGRAM

The first year of the three-year project, Bridging the Service Gap for Sexual Assault and Mental Illness Survivors, identified the gaps in services for people with a mental illness and, unlike other recent studies, it examined underlying issues regarding sexual abuse/assault and the need for services in Lambton County to address these issues. This study was conducted between August 2004 and June 2005. Data collection took place in the form of focus groups and personal interviews with a broad range of service participants from diverse local organizations. The interviews provided rich qualitative data on the perspectives and experiences of people who have accessed or attempted to access the services provided for those who have experienced sexual assault/abuse and have mental health issues in Lambton County.

The study, encompassing the region of Lambton County, examined the experiences of 112 people with serious mental illness (SMI) or moderate mental illness (MMI) who also have a trauma history of sexual abuse or adult sexual assault. The knowledge and practices of 68 service providers (managers, executive directors, legal professionals and front-line staff) added further information to the study. A copy of the results and recommendations from the report are available online at www.bridgingtheservicegap.com along with the description and evaluations of the programs that were developed as a result of the study.

The study resulted in 29 recommendations of which 16 were able to be incorporated into programs to address the identified issues. The following concept map, Figure 1, illustrates the development of initiatives to be addressed by three programs that would be developed, facilitated and evaluated in the last two years of the study. The mental health continuum indicates the range of mental health issues of service participants that are often the result of the underlying sexual trauma history. The three main goals of the original study were to improve existing services, reduce barriers to accessing services and bridge the gap in services.

Figure 1. Concept Map: Framework For Community Capacity Building



The Social Action Project (SAP) program was developed as a result of many of the themes that emerged from the analysis of the interviews. Service participants (88%) identified their own gifts, abilities, talents and experiences as important and felt they were underutilized within the community. The strengths of service participants are employed and developed under the category of **Participant Social Action Projects**. This program could be utilized to address the major themes of stigma (78% service participants), barriers in existing services (78% service participants and 63% service providers), informal support systems (76% service participants and 63% service providers) and problems with staff (75% service participants and 70% service providers). The project was based on the principle that all participant social action projects should be identified and chosen by participants and they must be based on the strengths of the group members.

SOCIAL ACTION PROJECTS MODEL

This multi-component program was designed to assist participants to build their communication and social skills, enhance their social networks, break their sense of social isolation by gaining social supports, and promote access to social and leisure activities while building planning and vocational skills. By sharing their skills and

symptom management strategies with their peers, participants could expand their own strategies and increase their sense of competence by helping others (Moses 2001). By working with peers who have experienced many of the same issues, they would be surrounded by acceptance when they shared any of the difficulties that may develop during task completion.

The Participant Social Action Project model was designed to provide a safe environment to build the necessary skills for interpersonal connections while promoting social change through education and awareness. This program focuses on wellness and is strength-based and collaborative (Corrigan 2002; Mazelis). It was designed to help build self-confidence, respect the dignity of participants and pass on skills and knowledge through the sharing of experiences. Being empowered, making connections to others, finding meaning in work and finding meaning in recovery and incorporating the experiences into a positive self-concept were the goals of the program. These goals were operationalized in the following ways:

- Providing a format for people who have experienced sexual trauma and mental illness to improve their quality of life
- Assisting participant “recovery” which is the process of transcending symptoms, psychiatric disabilities and social handicaps
- Incorporating a problem-solving model that will support participants in overcoming obstacles
- Providing a setting for the process of recovery: redefinition of self, the emergence of hope and the development of self
- Facilitating the group with the focus on collective empowerment
- Creating a safe social atmosphere for the establishment of meaningful relationships with others

Environment

Setting

When working with participants who have experienced sexual trauma and mental illness, it was considered important to recognize that both these experiences can carry a negative stigma in society. The location and setting of the group was chosen with this mind.

The Social Action Project program operated within the basement of a local church in downtown Sarnia. This location was chosen for several reasons. First, since it is located in the downtown area it is easily accessible by public transit. The downtown area is home to many who are among the community’s marginalized population. Second, it was believed that the church did not carry the stigmas associated with mental illness or sexual trauma service providers. The church also provided a venue large enough to accommodate the group size and the facilitation of tasks and activities requiring ample space and it gave access to kitchen facilities. Last, the use of the church basement was graciously donated free of charge to the program. The venue was discussed and approved at intake with all potential participants to ensure they were comfortable with the location and that it would not be a source of ‘triggers’ for sexual trauma or mental illness

symptoms. It was possible that some participants may have experienced their sexual trauma within a church setting, and the venue would have been changed if all participants were not comfortable with the setting.

Refreshments

Refreshments were an important part of the social interaction and social networking that was one of the primary goals of the Social Action Project program. As many people who have experienced sexual trauma and mental illness are often on fixed low incomes, refreshments included fresh fruit and vegetables and natural, rather than artificial, fruit juices. These were appreciated and any “leftovers” were divided amongst the group members to take home. It was helpful to order enough healthy refreshments to ensure that group members were able to benefit from the “treat” of healthy food which was often difficult for participants to obtain due to the constraints of low income.

Rationale for Professional Facilitators

The Social Action Project was staffed by facilitators of both genders. It was hoped that participants of various genders could be more easily recruited to a program that offered facilitation by both genders as part of its design. It is important in a mixed gender group that facilitators of both genders be present. Both present a positive role model of that gender, model the appropriate male/female relationships, increase the level of safety and allow participants to approach the gender of facilitator with whom they feel the most comfort. Given the population, steps were taken to show sensitivity to the comfort levels of individual participants with regard to the presence of a male facilitator. This was addressed during the intake interview where each participant was asked how she would feel about being involved with a project that included a male facilitator and the measures that would make her feel more comfortable.

The participants in the Social Action program had experienced sexual trauma and mental illness at some point during their lives. At the beginning of the project, it was considered that working on a project that addresses both sexual trauma and mental illness could possibly have a negative impact on an individual’s mental illness symptoms which could then affect the group dynamics. Therefore, it was important to put into place professional facilitators who would be available to assist group members in building a positive supportive environment in which symptoms could be managed, conflicts could be resolved and feelings of anxiety and fear could be expressed safely.

It was also important to have multiple facilitators (2-3 facilitators) involved in the program. One facilitator focused on the content of the project chosen by the group and he or she assisted in brainstorming ideas, breaking ideas into steps, and facilitating individual activities and tasks. The skills taught and utilized in content facilitation are those which are useful for managing everyday tasks that seem overwhelming. The other facilitator focused on group process and dynamics. It was vital for the participants and the success of the project that conflicts between group members could be discussed and resolved. The process facilitator was also able to identify potential issues and ensure that

constructive feedback was given. This allowed certain conflicts to be avoided. Multiple facilitators allowed for smaller group activities and tasks to be completed more easily. A facilitator was designated to subgroups that were formed to ensure the safety and respectfulness of the environment. The third facilitator ensured that there were always two facilitators in the room during any break or if a participant needed special attention outside of the room. This also ensured that the male facilitator was never left unaccompanied by a female facilitator.

Problem Solving Model

The problem solving model was introduced during each session after check-in when group members were asked whether they had experienced any challenges during the week while accomplishing their task and if they would like the team to work with them on the development of strategies to overcome the challenges. This process was designed to allow the individual to share the challenges and to normalize the process as others shared their own challenges. The sharing of strategies was encouraged to build the skills of all team members. The problem solving model involved articulating the challenge or “problem” clearly, brainstorming as many options as possible and then discussing the pros and cons of each idea. The list of options was narrowed by the removal of some suggestions that were not deemed to be as helpful or feasible. The remaining ideas were examined and the positive or problematic outcomes of each were discussed. An idea was then chosen that seemed the most practical and possible for solving the problem. The option was then put into action and evaluated as to its outcome. This is an excellent problem solving model that is a useful strategy for navigating any challenge in life. This model was introduced to reduce anxiety and to expand the awareness of multiple options which could assist participants to overcome “black or white” thinking.

Conflict Resolution

When working on a social action project, many of the sessions are devoted to brainstorming ideas and choosing a direction from the ideas. The possibility arose that group members might feel that their ideas were being criticized and that this could be perceived as a form of personal attack. The facilitators’ role was to ensure that the process of analyzing the idea using pros and cons remained focused on the practicalities of the idea or suggestion and did not involve comments about the person who offered the idea.

The participants were clearly instructed that any conflicts within the group between members must be directed to the facilitators. The facilitators dealt with issues that could be addressed within the group. Issues that were personal between certain group members were addressed individually with the group members involved. It was important for the safety of all group members that a *Standards of Conduct* form be signed at the intake interview so that all members had a copy of the behavioural expectations and the behaviours that could lead to a request for an individual to leave the group (either temporarily or permanently). In order for participants to feel safe enough to try new tasks or skills that were perceived as risky to them, it was vital that team building

exercises be facilitated and the atmosphere in the group remained supportive. Conflict resolution was a very important element in the Social Action Project group program as group members, when under stress, may revert to unhealthy expressions that could impact on others.

Therapeutic Considerations

Expectations and Rules of the Group

A contract was developed and reviewed with each group member during the intake process. The contract outlined the formal aspects of the group process and clarified the roles, expectations and rules of the group. This contract was written and signed by those involved, as some mental illness symptoms or disassociative states can interfere with memory. A written contract provides clear guidelines to which members could refer throughout the group process (Crowder 1993).

Group members needed to be reassured that discussions and activities within the group would be confidential and that their personal information would not be shared by the facilitators with other group members. A confidentiality form was signed by all group members and this was reviewed at the beginning of each group in some form of simple statement such as, “What is said and done in the group stays in the group”.

Working on a social action project that invited group members to try new tasks and risk-taking activities required a safe environment. In the first session of group the members brainstormed what “safety” and “respect” meant to them and a handout was developed to be reviewed at the beginning of each session. As noted above, in order to ensure the safety of all group members, a *Standard of Conduct* form was signed by each group member that clearly outlined the behaviour expectations and the behaviours that would result in a request for a person to withdraw from the group.

Safety

It is vital that participants feel safe in order to engage in activities that may be perceived to involve some level of psychosocial risk (hereafter referred to as risk-taking). The Social Action Project was designed to assist participants to push past self-imposed limits and this involved stepping outside their comfort zone and trying new activities, engaging in new behaviours and voicing their ideas and opinions. To ensure safety in the group, every participant reviewed and signed a contract at the intake that outlined the standards of behaviour for all group members. It was important to include rules which specified that no touching or hugging was permitted unless permission is given by the participant. This models clear boundaries.

Crisis Plans

It was considered important that group members were aware of the support services available from the facilitators of the Social Action Projects and these boundaries were communicated clearly. The facilitators in the pilot program were available by telephone between sessions to answer any questions or concerns that arose from the session or the

task that the group member had chosen. It was found that this alleviated a great deal of the stress experienced by participants. A task chosen during the session when enthusiasm was high often was experienced as overwhelming when the group member was working in isolation between sessions. The facilitators could assist the participants to build their skills by brainstorming, discussing with the group members the steps that could be taken to achieve the completion of their task, or offering reassurance that the participant was managing the task well.

Each participant was involved in individual counselling to assist them with personal issues or trauma issues that may have been triggered by the group process or by the content of the project chosen. As the group was not a clinical counselling group and the facilitators were not cognizant of the details or history of the sexual trauma history or mental illness, it was important that all participants have individual counsellors to assist them in times of crisis. Planning with their individual counsellors for possible crises can support the participants risk taking and reduce their anxiety.

It is also important that participants be reassured that, if they are not able to complete their chosen task, they can contact the facilitators for assistance or return to the group in the next session and the team will assist them by using the problem solving model discussed at intake and in the orientation session.

Rationale for a Group Format

The value of group programs for the treatment of trauma has been well established in the literature (Crowder 1993; Wallis 2002). People who have experienced sexual trauma and mental illness often express a great sense of isolation from others for many reasons. Those who have experienced childhood sexual trauma may have grown up feeling different from others and some trauma survivors have a deep mistrust of others. Mental illness symptoms may impact on social skills. Whatever the reason, social isolation can be debilitating. Stigma experienced by people with mental illness in combination with a sexual trauma history often impedes their ability to connect with others as they worry about being judged by others. Involvement in a group with others who have shared similar experiences can alleviate many of their fears and break the sense of isolation. Associating with those who have similar personal and interpersonal difficulties may serve to normalize these problems.

Group work encourages interactions and relationships between members. By helping others, sharing skills and knowledge and supporting other group members, participants can increase their own sense of mastery and find connections with others. Group interactions provide a venue to explore new social skills and new behaviours in a supportive environment (Wallis 2002).

Rationale for a Mixed Gender Group

It is important to note that the Social Action Group is not a therapeutic process group that addresses the issues of sexual assault/abuse and mental illness symptoms. This group

was developed at the request of people who have had these experiences and who wanted an opportunity to share their strategies, skills and strengths with others. The study, *Bridging the Service Gap*, indicated that people wanted to give back to the community, they wanted to create something meaningful from their experiences and they wanted to address stigma by educating others about the issues.

The study also revealed the difficulty that many men have in finding and accessing services to address their own sexual trauma issues. The nature of the socialization process for men in western society creates an environment in which men often find it very difficult to address sexual abuse experiences. It was identified that a program that focused on the development of resources through task related activities would be more acceptable to men than a group that focused on the psychological and emotional issues of sexual abuse.

The segregation of genders in therapeutic groups addressing sexual abuse is based on the concept that men and women often do not feel comfortable in expressing their emotionally charged material and experiences in a mixed gender group and that their sense of safety could be compromised. However, since the Social Action Project program was not designed to address the experiences and feelings about the abuse and self-disclosure of these experiences was not encouraged, the underlying rationale for gender segregation was not considered to be a precondition for group membership.

Most survivors of sexual trauma and mental illness associate with both genders in their daily lives and a group that includes both genders allows the group members many opportunities to expand their social skills and comfort level within a safe, supportive environment with trained facilitators present. Working on a project together and sharing tasks can create a context that facilitates conversation about the project that does not rely on social skills yet the team building exercises promote ease of social interaction through laughter and play. The development of social and communication skills with both genders is important for the healthy functioning of people in society. However, as is noted below, no men were recruited for participation in the current project (i.e. no men contacted the project team to request information about participation in the project). This, the project proceeded following the recruitment of ten women.

Group Rules

Safety is a priority and, as was noted above, written group rules clearly outlined the behavioural expectations. The facilitators monitored group dynamics and at each session reviewed the values of respectful listening and constructive comments. It was clearly indicated that any interpersonal difficulties were to be brought to the facilitators' attention and that they would be addressed immediately after the meeting or, in the case of direct confrontation, the people involved would be taken aside for a private meeting.

During the first session, each participant reviewed and signed the consent form for participation in the pilot program. The consent form was read out loud by a facilitator and any questions concerning the program or evaluation procedures were answered.

Each participant developed personal goals that she hoped to attain through participation in the program and goals that she hoped the project would meet for the community. Both the *Standard of Conduct Form* and *Oath of Confidentiality* were reviewed by each participant. Participants were reassured that the group would be confidential and that their personal information would not be shared by the facilitators with other group members.

Group Structure

Each session began with a social component. The team building activities and refreshments provided an opportunity for participants to socialize and to begin establishing relationships with peers.

It was acknowledged by the facilitators that mental illness symptoms or fears could interfere at times with successful task completion and a problem solving model was introduced at the beginning of each session so that participants were supported by their team in building strategies to overcome any obstacles encountered.

The Social Action Projects program was designed to provide opportunities for participants to develop their leadership skills through rotating team leadership and team recorder roles. Leadership roles increase a person's sense of power and control which counteracts typical feelings of powerlessness; it offers choices, promotes independence and group empowerment (Mowbray, Robinson, Holter 2002; Moses 2001). Participants were encouraged to volunteer for these roles. After the team building activities, the team leader commenced the session by reviewing the group's "to do" list. The team leader initiated the group discussions and engaged members in a review of what was accomplished during the previous week and what challenges were encountered.

Team members then worked on the project together. This often required a review of the project time line and brainstorming ideas to assist in task completion. The participants chose tasks on which they wished to work. Working on task completion for the project provided an opportunity for participants to interact in a positive manner and share their skills and knowledge with each other. It allowed participants to expand their leadership abilities, social and communication skills, problem-solving abilities and expand their sense of competency.

Maintaining Motivation

Social Interaction

One of the main goals of the Social Action Project was to reduce group members' sense of isolation and give participants opportunities to socialize in a safe environment while building their interpersonal skills. Participants had articulated the need to engage in social interactions with people who had experienced sexual trauma and who had a mental illness as they believed that in such a group they would be interacting with others who would understand their difficulties and who would be able to offer support and assistance.

Each session began with a social component that involved fun team building exercises and refreshments. The social aspects of the program were seen as strong motivators as participants looked forward to spending the time together. Further, it seemed that group members developed a sense of belonging and affiliation during the process.

Team Recognition

In order to maintain motivation in the program, individual and group successes were celebrated by the group. Tasks completed by individual group members between sessions and project milestones were recognized by the group. Individual task completion was acknowledged by clapping and gold star stickers placed beside individual names on flip chart paper and in individual binders. “You did it” coupons were also given out for individual task completion, which were traded in at the end of each session for a “super silly” prize. Similarly, project milestones accomplished by the group were acknowledged with cheers, clapping, and verbal praises.

Positive feedback through peer recognition assisted team members to incorporate their skills and accomplishments into their self-concept which, in many cases, was built around perceived limitations they experienced in daily living as a result of their trauma experiences and mental illness.

Support

At the beginning of the program, facilitators recognized that group members may be challenged by some aspects of the program. Various forms of support were offered to participants throughout the process to assist them in overcoming these challenges. Some of the challenges included triggers, flashbacks, difficulty with task completion, issues associated with self-worth and confidence level, and others. Support was offered to individual participants on an “as needed” basis. This support was offered by the group facilitators over the telephone and during personal interviews in between group sessions. Therapeutic letters were also sent to participants during the process. The therapeutic letters offered words of encouragement, appreciation, support, and praise.

Project Selection

Participants began the process of project selection by brainstorming ideas that would raise public awareness and educate the public on issues related to sexual trauma and mental illness. Themes that emerged from the brainstorming session included fundraising, education, lobbying efforts and art exhibitions. Examples of projects included a quilt draw, posters/brochures, petitions for government, and an art show displaying works from survivors of sexual trauma.

A short list of projects was then created by participants in an effort to narrow the selection. This process was accomplished by each member selecting one or two projects from the larger brainstorming list for closer consideration by the group. When deciding on a project, consideration was given to the amount of resources (time, money, workforce, materials) the project demanded. Thus, group members considered the pros

and cons of each project on the short list including the cost of the project, the amount of time needed for its completion, and talents and skills of group members. It was important that a consensus was reached by the group members to ensure that each participant was invested in the project.

The skills of brainstorming, evaluation and problem-solving were incorporated into every session and this method assisted group members to lower their fear of risk-taking as “mistakes” were considered evaluative feedback instead of personal “failure”. Any challenges that arose were addressed by the team and new strategies for managing the difficulty were developed by the team. The results of the new strategy were evaluated by the team.

Ethical Considerations

The first year of the Bridging the Service Gap study commenced after approval by an adhoc ethics review committee in Sudbury which outlined key ethical principles to be followed. Participants of the Social Action Project signed consent forms indicating they were aware that this was a pilot program and that data would be collected for the purpose of program evaluation. It was acknowledged by the facilitators that participation in the group could increase anxiety and symptoms as new strategies were learned and participants engaged in activities that moved them out of their comfort zone. Each participant in the program was involved with an individual counselor at the Sexual Assault Centre. Lastly, support was given by the facilitators of the program through telephone calls and personal interviews.

Media Launch of Project

The Social Action Project is a project developed by group participants to be used by the community to educate the public and increase awareness of the issues in order to reduce stigma and its negative influence on the lives of those who have been sexually traumatized and who have a mental illness. The project participants chose to develop and produce a puzzle that could be used as an educational tool within the school system. The puzzle was fully developed and a large scale prototype was produced in full colour plexi-glass by a local company (see Box 1). It was important to formally present the project to the community in order to ritually finalize the project and allow participants to engage in a meaningful presentation of their work. The attendance of the media was helpful to disseminate the information about the project and to acknowledge the importance of the project chosen by the social action project participants. It was helpful to invite community agencies and dignitaries (mayor and stakeholders) to the presentation as they received the completed project on behalf of the community.

Box 1. Puzzle Created by the Program Participants



EVALUATION OF THE PROGRAM

EVALUATION GOALS

The evaluation of the pilot program Social Action Projects examined several areas of the program:

- Examine the extent to which the actual implementation of the Social Action Projects program matched the original program design goals for participants:
 1. Provide a format for people who have experienced sexual trauma and mental illness to improve their quality of life
 2. Assist participant “recovery” which is the process of transcending symptoms, psychiatric disabilities and social handicaps
 3. Incorporate a problem-solving model that will support participants in overcoming obstacles
 4. Provide a setting for the process of recovery: redefinition of self, the emergence of hope and the development of self
 5. Facilitate the group with the focus on collective empowerment
 6. Create a safe social atmosphere for the establishment of meaningful relationships with others
- Document the evolution in the content of the Social Action Projects program sessions as they responded to context changes
- Examine the program’s processes – how the program unfolded and how participants moved through the program
- Look for unanticipated outcomes, side effects and unexpected consequences in relation to the primary program processes, outcomes and impacts

RATIONALE FOR MIXED-METHODS, PRIMARILY QUALITATIVE DESIGN

Qualitative methods are often used in program evaluation because they capture the program’s outcome by communicating the participants’ perception of what happened, to whom, and with what consequences. Understanding the program’s and participants’ stories is useful to the extent that the processes and outcomes of the program are identified for those who must make decisions about the program and those who would build on the work. In this project, qualitative methods illuminate the people behind the numbers and put faces on the statistics to deepen understanding of their experiences.

PROCEDURE

Purposeful Sampling Strategy

Participants were strategically and purposefully selected to ensure they had experienced sexual trauma and mental illness and were above the age of 16 years old. All agencies and stakeholders involved in the project and the general public were informed of the Social Action Projects program in order to attract a wide range of participants to get variation on dimensions of interest and skills. No specific group size was predetermined as it was believed that the program could accommodate a large number of people.

Recruitment***Posters***

Posters were developed that focused on the personal goals that were articulated by people who had experienced sexual trauma and mental illness and who chose to be interviewed in the first year of the study. Posters were placed in organizations and agencies frequented by this population as well as public venues (grocery stores, variety stores, malls).

Brochures

Brochures were developed for service providers to inform them about the social action project program and encourage referrals to the program. Brochures were also developed for potential participants that could be distributed by organizations to describe the program and provide contact information for the project leaders.

Media Launch

At a workshop for another program developed by the Bridging the Service Gap study, an announcement was made about the Social Action Project program to the attending media. The media coverage ensured that the public would be aware of the new program and that potential participants could be invited to contact the project team for more information.

A press release about the project at its inception and one sent to the media upon completion of the project ensured that the community was aware of the Social Action Project. A press release resulted in radio and newspaper coverage through interviews with facilitators and that was effective in attracting participants and advertising the final project.

Organization Referrals

Community organizations and agencies were given a package with extensive information about the program, criteria for admittance to the SAP, the referral process and brochures to give to potential participants. The target group focussed on people who were accessing services that assist them with their issues around the sexual trauma and mental illness.

Assessment Interview Screening

All potential participants were interviewed by the male and female facilitators of the program so that participants would have the opportunity to meet the facilitators in order to reduce the anxiety of meeting new people when the group started. The intake interviews took place at the church chosen for the group venue or at the Sexual Assault Survivors' Centre Sarnia-Lambton if the church was not available. It was considered helpful for the intake interview to take place in the location in which the group would be held to ensure that the group members would have some familiarity with the setting before group started. Participants may find entering an unknown building and finding a specific room difficult when they are already anxious about meeting other group members for the first time and starting a group with which they have no prior experience.

Having the intake interview, when possible, in the room or at least the building where the group would take place ensured a measure of familiarity at a potentially stressful time.

The intake interviews followed a semi-structured format and were designed to explore the strengths and skills of each participant. The facilitators explained the program, gathered demographic information, clinical variables (trauma history, mental illness diagnosis, number of hospitalizations), and social supports. As was explained above, both a *Standard of Conduct* form and an *Oath of Confidentiality* form were reviewed and signed by participants. Participants for the Social Action Project were selected based on criteria of having experienced sexual trauma, having a mild, moderate to severe mental health problem, and being over sixteen years of age. As this pilot program was under the mandate of the Sexual Assault Survivors' Centre Sarnia-Lambton, there were certain factors that excluded a person from participation in this program, as follows.

- A participant who has participated in abuse-reactive perpetration of sexual abuse/assault
- Therapeutic considerations that could preclude a placement in the program.
- A present crisis in one's life that was experienced as overwhelming
- Mental illness symptoms not being managed by participant (i.e. delusional, bizarre thinking, hallucinations, extreme paranoia)
- Any behaviours that would compromise the safety of the other group members (e.g. rage and aggressive behaviours, extreme prejudice voiced against another race)

Sample

In order to ensure that they met the criteria for the program, ten participants were screened before being accepted into the Social Action Project. The intake involved ensuring participants were over sixteen years old, exploring whether they had trauma history of childhood sexual abuse and/or adult sexual assault (specific information was not sought about the nature of the sexual abuse or assault), and determining whether they had a psychiatric diagnosis or symptoms of mental illnesses. All participants interviewed at intake were admitted to the program and all had been referred from area organizations with the majority of referrals coming from the Sexual Assault Survivors' Centre Sarnia-Lambton.

The goal was to include people of various genders, ages and ethnic backgrounds. In addition, the program sought to include those who had disabilities and people from diverse socioeconomic groups.

Demographics of Participants

Gender

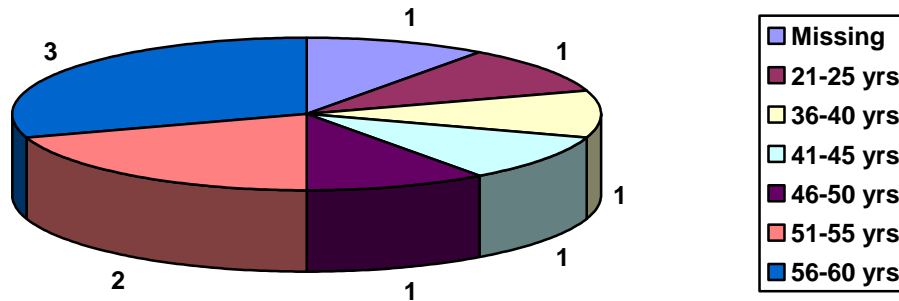
All ten participants who requested involvement with the Social Action Project were women. This may indicate that fewer men access services, in particular services specifically related to sexual abuse/trauma. Further, it may be that, in our society, it is more acceptable for women to acknowledge the sexual abuse or sexual assault that takes

place in our society. During the first year of the project, men comprised nine percent of the chart review sample and 30 percent of the interview sample. However, these same numbers were not represented in the Social Action Project. Further studies should be conducted to examine the needs of men who have been sexually abused and perhaps the obstacles to accessing services. Male participants in the first year of the study had suggested that a group that did not specifically address sexual abuse issues but, instead, focused on a task, would be more appealing for male participation. This information was considered when developing the model used for the design of the Social Action Project. Despite this format, men did not respond to the advertisement and did not follow through with referrals from organizations.

Age Distribution

As shown in Figure 2, the age range of the participants was 20s to 60s. However, the largest age group in the program was the group 56-60 years. The mean age of those interviewed in the first year of the project was 42 so the age composition of the participants of the Social Action Project program was slightly older than the population that initially made the recommendations that resulted in the program being developed.

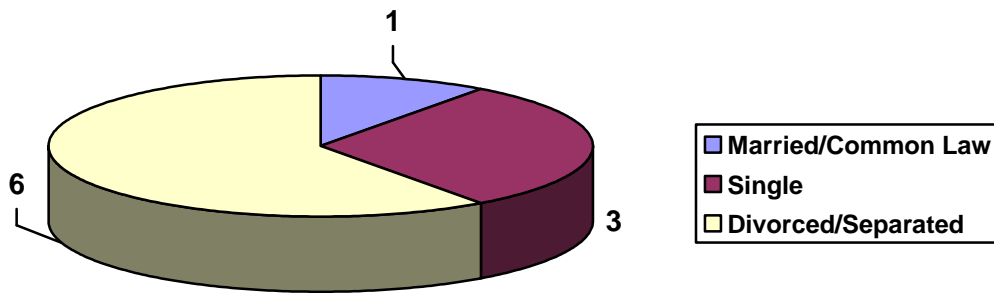
Figure 2: Age of Participants



Marital Status of Participants

Of the adult population in Lambton County (Statistics Canada, 2001), approximately 58 percent were married, 27 percent were single and 10 percent were divorced or separated. As shown in Figure 3, the majority of participants in the Social Action Program were divorced, separated or single which were key factors in the demographic profiles of people who had experienced adult sexual assault or ASA (Chandra, et al, 2003). The literature suggests that relationship difficulties are frequent among people who have mental health problems.

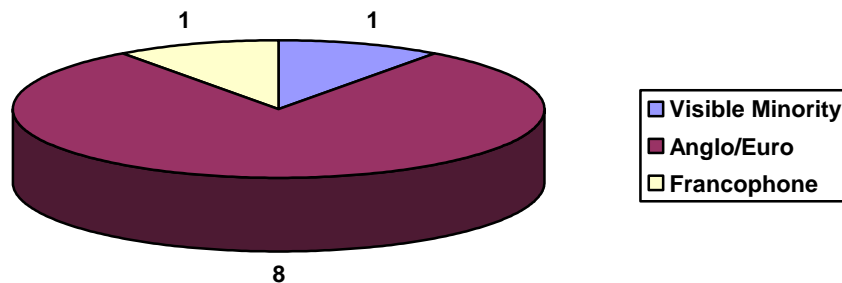
Figure 3: Marital Status of Participants



Ethnicity of Participants

According to the 2001 Census, Lambton County has a population of 125, 565 people (Statistics Canada, 2001) and it was the goal of the Social Action Program to be representative of the ethnic diversity in the community. The majority of participants self-identified as being English speaking Canadians of European ancestry. Anglo-Europeans are 91 percent of the population in Lambton County and at 80 percent of the participants in the program, they are adequately represented. The Francophone community and visible minorities both represent two percent of the population in Lambton County. It is notable, then, that one participant from each of these ethnic groups was attracted to and volunteered for the program (see Figure 4). The aboriginal population comprises four percent of the population of Lambton County and is a notable absence from the Social Action Program.

Figure 4: Ethnicity of Participants

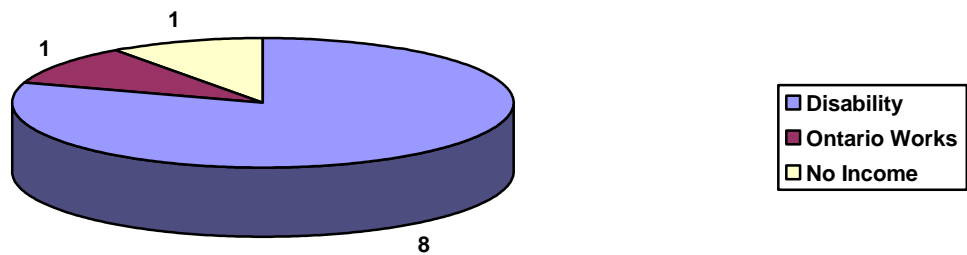


Sources of Income for Participants

Lack of employment was one of the key factors identified in the demographic profiles of people who had experienced ASA (Chandra, et. al. 2003). The participants in the Social Action Program had difficulty in obtaining employment as most of the group members were in receipt of some form of social assistance. The majority of participants (eight of ten) derived their income from disability income supports (see Figure 5). One participant of the Social Action Project was employed on a part-time basis. Another participant who

was not in receipt of social assistance had no independent source of income. This participant was in a married/common-law relationship and was financially supported by her partner. In Lambton County, 78 percent of the population is employed on a full-time basis while 16 percent of the work force is employed on a part-time basis (Statistics Canada, 2001). It may be that participants in the program are having difficulty managing symptoms of SMI or MMI as well as the trauma symptoms associated with childhood sexual abuse and/or sexual assault. As a result, maintaining full-time or even part-time employment is difficult.

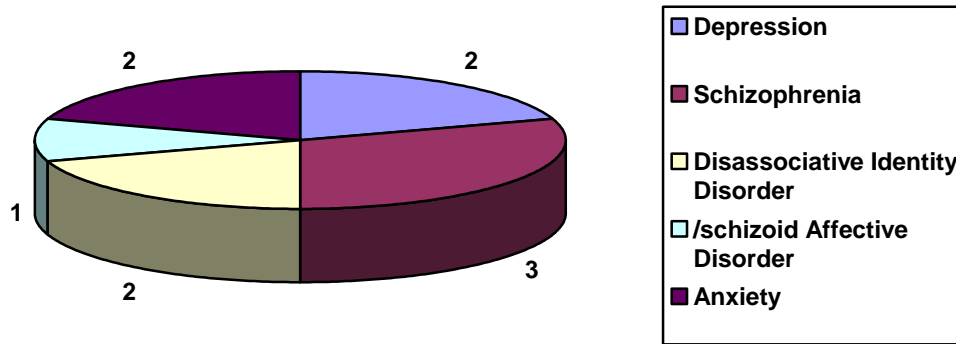
Figure 5. Main Source of Income



Most Responsible Diagnosis (MRD)

The MRD is the diagnosis that is the most severe and problematic for a particular person. The highest frequencies of diagnoses in the sample from the Social Action Project were depression (3 participants), dissociative identity disorder (2 participants), and schizophrenia (2 participants). Other MRDs included anxiety and schizoid affective disorder. One participant did not report having a formal diagnosis but mentioned symptoms of anxiety (see Figure 6).

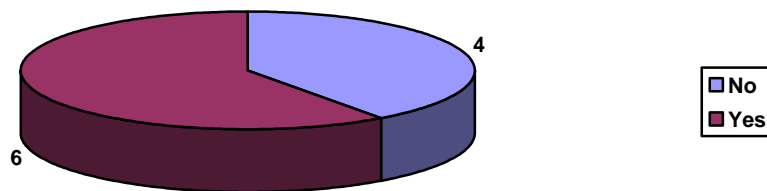
Figure 6. Most Responsible Diagnosis



Multiple Diagnoses

The majority of participants in the program had multiple diagnoses/ symptoms (see Figure 7). Out of the ten participants who completed the intake process, six reported having multiple diagnoses or symptoms other than their most severe or problematic diagnosis. Depression and anxiety were the most frequently reported diagnoses among participants with six group members indicating these diagnoses. Other SMI diagnoses reported by participants included bipolar (2 participants) and schizophrenia (2 participants). Other diagnoses reported by participants included post traumatic stress disorder and sleep disorder. The most common combination of disorders among participants was depression and anxiety (5 participants). Current literature indicates that there is a compelling association between childhood sexual abuse and a dual diagnosis of depression and anxiety (Leviton, Rector, Sheldon & Goering, 2003).

Figure 7. Multiple Diagnoses

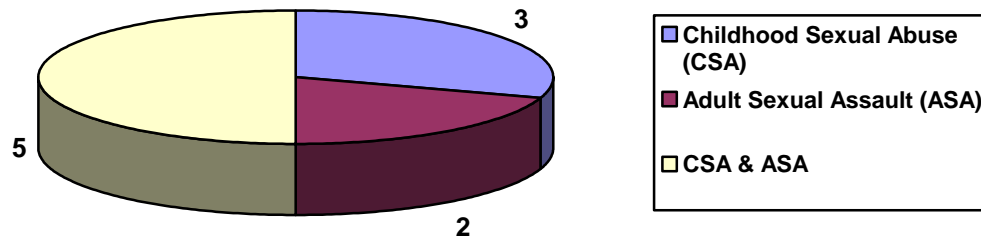


Experiences of Sexual Abuse/Assault

As shown in Figure 8, the majority of participants in the Social Action Program had experienced both childhood sexual abuse and adult sexual assault (5 participants). Three participants had solely experienced childhood sexual abuse and two participants had solely experienced adult sexual assault. Published literature on this topic has identified the connection between childhood trauma and further victimization later as an adult (Baynard, Williams & Siegel, 2001). One episode of childhood sexual abuse may be sufficient to place the survivor at higher risk for later sexual assaults (Maker,

Kemmelmeier & Peterson, 2001). Every subsequent sexual abuse incident or sexual assault may further complicate the prognosis for recovery.

Figure 8. Experiences of Sexual Assault



DATA COLLECTION

Various qualitative and quantitative methods were used to collect data during this study. Participants in the program and facilitators of the program contributed information through written documents, audio-taped interviews, evaluation forms and observations.

Participants

Goals Sheets

During the first session of the program participants developed goals they hoped to attain through participation in the group and goals they hoped the project would meet for the community. Identifying personal goals allowed participants to set their own targets with regard to the outcomes of the program. Opportunities for reflection on personal goals existed throughout the process in the form of session evaluation surveys and a focus group at the completion of the project. Questions during the focus group interview asked participants to reflect on their personal goals and to state whether their goals had been achieved. Their responses were transcribed verbatim and coded electronically with QSR NUD*IST 6.

Evaluation Forms

Evaluation forms were administered to participants at the completion of each session. The forms were designed to allow participants to give qualitative and quantitative feedback about each session. This provided facilitators with immediate feedback about group processes, content of the particular session, and participants' satisfaction level with the program. Qualitative information from the forms was recorded electronically into SPSS (Statistical Package for Social Sciences Version 11.0).

Focus Group Interview

A focus group was held with participants at the completion of the Social Action Program. The focus group followed a semi-structured format and was facilitated by a Social Worker (M.S.W.) who was not a part of the Social Action Project program. The data collected related to the projects goals, objectives, group structure, and recommendations for change. It provided an opportunity for participants to give feedback about their experiences in the program. Open-ended group interviewing captured participants' experiences and perspectives on the program being evaluated in their own terms. Since a major part of what happened in the program was provided by the participants, it was vital to record their impressions, stories and recommendations verbatim.

As part of this process the focus group session was transcribed and then manually coded using the questions from the semi-structured interview guide. Emerging themes were identified and categories and subcategories within each theme documented. The transcript was then formatted for use with QSR NUD*IST 6 (Non-numerical, Unstructured, Data-indexing, Searching, Theorizing), a qualitative data analysis software package (N6). Using themes identified manually, the transcript was then coded electronically, which allowed for further refinement of the codes.

Unsolicited Data

Unsolicited information was also provided by participants and subsequently recorded for use in the analysis of the program. These data were provided through notes, letters, and telephone calls to group facilitators. This process was encouraged by the professional facilitators in order provide immediate responses to comments and concerns about the program and to provide support to those participants experiencing difficulties with the process. As a pilot project, the information was valuable in the analysis of the project and assisted in the development of recommendations and considerations for future projects.

Facilitators

Field Observations

Facilitators met immediately following each session for the purpose of debriefing. The debriefing process was necessary for facilitators to share personal and professional reflections, concerns, suggestions, and self-reflection of what took place during the sessions. All the information collected on content and process was used to continually evolve the structure of the program. The program was designed with great flexibility to allow all data collected at each session. The three facilitators discussed group dynamics, process, and changes that needed to be made. Handouts were developed in order to respond to the emerging content and the group process. For example, a handout on respect was developed during the early stages of the group in order to reinforce this notion with group participants.

Qualitative Notes

The lead researcher kept qualitative reflective notes pertaining to the process. This included the facilitators' impressions and notes about what happened during and between

group sessions. This provided documentation of the entire process of project development, group facilitation, and group process.

Research Log

A formal research log was also kept as part of the process. This provided a record of all meetings, sessions, and decisions to accurately reflect the group process and project development. Further, it was used in the development of a project manual.

DATA ANALYSIS

Procedures

Triangulation in the forms of multiple methods of data collection and analysis was used to provide for standards of verification in the evaluation. Data were collected using multiple sources including participant evaluation forms, observations, qualitative field notes, research log, focus group and interviews. The data analysis process was aided by the use of computer programs including Statistical Package for Social Sciences 11.0 (SPSS 11.0) and QSR NUD*IST 6. These software packages facilitate the recording and analysis of textual and graphic data. The focus group interview was transcribed verbatim and manually coded using the questions from the semi-structured interview guide. Emerging themes were identified and categories and subcategories within each theme documented. The transcript was then formatted for use with QSR NUD*IST. Using the themes identified manually, the transcript was then coded electronically, which allowed for further refinement of codes. Using SPSS the researchers were able to summarize and graph data.

DISCUSSION OF RESULTS

“Don’t you wish you could take the respect, the understanding, the acceptance that we find from this group and walk out those doors and have that same thing out there?” (SAP participant)

Evaluation forms completed at the end of each session showed that, overall, the participants were highly satisfied with the content of the sessions. Even though some participants did not attend some of the sessions, they expressed satisfaction with those they attended. As Figure 9 shows, the number of participants in each session varied between three and eight. One participant who was initially recruited did not attend any sessions. On average, five of the remaining participants attended the sessions. However, non-attendance at one or more sessions should not be viewed as an indication of dissatisfaction with the group process since the qualitative data from the focus group with participants revealed that a number of participants regretted that they had to miss some of the sessions due to other commitments or obligations (see Table 1).

Figure 10 shows the ratings provided by participants attending the eleven sessions. Based on 60 completed evaluation forms, 77 percent indicated that the sessions were “great”. Only eight percent of the evaluation forms indicated that the sessions were poor while 15 percent indicated a neutral response. Figure 11 shows the overall satisfaction level of the

participants based on the question, "I'm glad that I attended" and shows that 95% of the 60 responses were positive.

Figure 9. Participant Attendance in Each Session

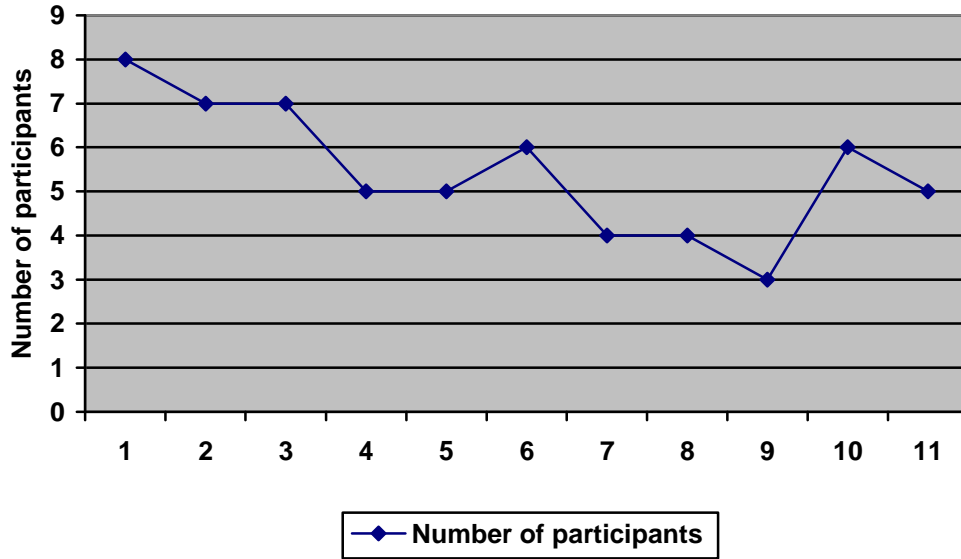
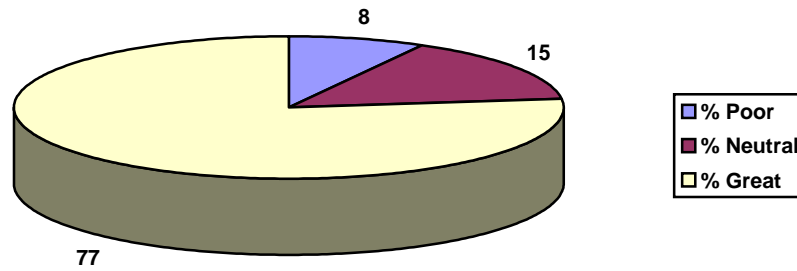
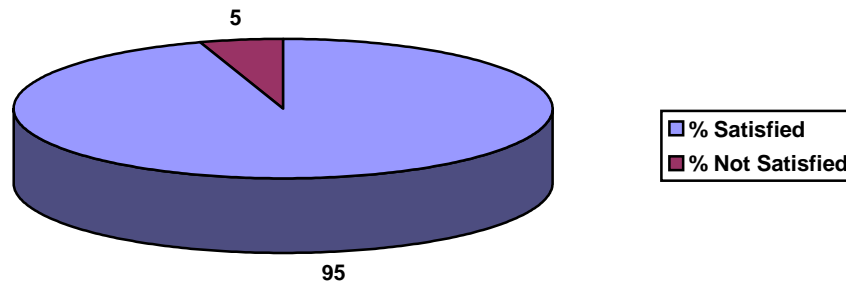


Figure 10: Participant Ratings of all Sessions



**Figure 11: Participant Satisfaction
with all Sessions**



FOCUS GROUP RESULTS

Participants' Perceptions of the Benefits, Process Issues and Challenges of the Program

"[The experience was] awesome. We were able to see our own strengths as individuals and as a team. I thought we all worked well together. At least we learned to, I should say. We learned to work well together as time went on. Getting to know each other better, and our strengths and weaknesses, and then blending what was necessary to make it work". SAP Participant

Table 1 summarizes the results of the focus group held with the Social Action Project participants. Table 1 also indicates whether the themes or issues were mentioned in the evaluation forms which participants completed after every session. The main themes emerging from the analysis pertained to the benefits, process issues (positive and negative), and the challenges associated with participation in the group. The participants also made recommendations for future groups and these are included in the section listing recommendations.

There was great consistency in the types of comments made in the focus group and in the weekly session evaluation forms completed individually by the participants. Table 1 indicates that there were only three themes/issues mentioned in the evaluation forms that were not explicitly mentioned in the focus group. These three issues pertained to the access to food and beverages, the organization and quality of the handouts within sessions, and the impact of the arrangement of the furniture within the room on the feelings of safety/well being of the participants. All other issues listed in Table 1 were mentioned in both the focus group and the evaluation forms.

Table 1. Analysis of Focus Group Data: Themes Identified by the SAP Participants

Benefits of participation	Focus Group	Evaluation Forms
<ul style="list-style-type: none"> Making new friends, socializing and developing social skills, social support received from group members and the non-judgemental approach to the group and being validated 	✓	✓
<ul style="list-style-type: none"> Gaining deeper awareness of various issues/impacts of sexual assault 	✓	✓
<ul style="list-style-type: none"> Having fun 	✓	✓
<ul style="list-style-type: none"> Providing a valuable learning experience/learning by discussing ideas 	✓	✓
<ul style="list-style-type: none"> Gaining satisfaction, self-confidence, pride in group accomplishments 	✓	✓
<ul style="list-style-type: none"> Appreciating time spent doing something productive 	✓	✓
<ul style="list-style-type: none"> Having access to good food and drinks 		✓
Process Issues		
<i>Positive</i>		
<ul style="list-style-type: none"> Participating actively in discussion and being respected and listened to/being given the opportunity to take on a leadership role/good teamwork 	✓	✓
<ul style="list-style-type: none"> Being given the opportunity to discuss risk-taking 	✓	✓
<ul style="list-style-type: none"> Reviewing respect chart and ground rules in each session 	✓	✓
<ul style="list-style-type: none"> Having female and male facilitators/effective facilitators 	✓	✓
<ul style="list-style-type: none"> Having the role of the facilitators appropriately defined 	✓	✓
<ul style="list-style-type: none"> Having well organized sessions and good handouts 		✓
<ul style="list-style-type: none"> Games, brainstorming activities, silly prizes, stickers, physical exercise 	✓	✓
<ul style="list-style-type: none"> Accessible location 	✓	✓
<i>Areas for further development</i>		
<ul style="list-style-type: none"> Feeling self-consciousness or nervous at the beginning of the project 	✓	✓
<ul style="list-style-type: none"> Especially at the beginning of the program, paying attention to the arrangement of furniture in the room so that it meets the needs of participants 		✓
<ul style="list-style-type: none"> Addressing a lack of privacy at times in the meeting space/disruptions and noise/impacts on perceived sense of safety 	✓	✓
<ul style="list-style-type: none"> Ensuring that there is enough time for informal, unstructured time with other group members 	✓	✓
<ul style="list-style-type: none"> Needing more time for structured group activities/effective time-management 	✓	✓
<ul style="list-style-type: none"> Using strategies for stress management to support participants in dealing with a demanding program and with setbacks in project development 	✓	✓
Challenges		
<ul style="list-style-type: none"> Addressing specific behaviours or communication patterns 	✓	✓
<ul style="list-style-type: none"> Dealing with absences from the group 	✓	✓
<ul style="list-style-type: none"> Addressing the lack of flexibility in the length of each group session and the length of the program 	✓	✓
<ul style="list-style-type: none"> Explaining funding constraints 	✓	✓
<ul style="list-style-type: none"> Addressing group discussion that acted as emotional triggers for some group members 	✓	✓

Benefits

A key benefit of participation in the SAP group was making new friends, socializing with people who have had similar experiences and developing social skills (e.g. developing better communication skills). Connecting with others helped the participants through the knowledge gained about shared experiences (e.g. participants' gaining knowledge that they are not alone and that there are others in similar circumstances). The non-judgmental approach within the group was an important aspect that enabled participants to benefit from involvement in the project. *"We know we're not being judged in any way"*. Support gained from other members of the group was valued. Some developed friendships that extended beyond the SAP group setting.

"Somebody heard me and could say the words that I couldn't explain...it was truly a gift...it was very touching."

A perceived benefit for the group members was related to the opportunity to gain awareness of the various issues linked to the healing process for other participants. For example, it was noted that issues raised within the group pushed participants to work on and deal with their own issues.

"It knocked me off my perch. I was getting complacent considering I had worked out my strategies and I was coping, and it showed me that I wasn't coping as well as I thought, and I couldn't just rest but I had to keep doing the work."

"This social action project, has helped me understand, some very important aspects, about myself."

The Social Action Project group provided a range of experiences that were different from those associated with their lives outside of the group. They mentioned that they had fun with the games and various motivators used as part of the group process.

The participants also valued the learning experience, especially the ways in which they learned from the ideas, knowledge and skills of other participants. The participants became aware of the strengths of others in the group and felt validated by learning that others in the group valued their comments, skills, talents and contributions. *"Working on the project... reminded me that what I knew and used in the past, I still know and I can still use [it]; there's a place for it"*.

The participants benefited from satisfaction, pride and increases in self-esteem or self-confidence that stemmed from the accomplishments of the group and having an opportunity to make an impact on the understanding of sexual assault and its impacts among the general public, government, medical personnel and police. *"We did something that matters. I think that it will help [raise] awareness about sexual violence and the effects that it has on people for a lifetime"*.

These accomplishments made the participants feel empowered and the experiences shared within the group increased self-confidence. *“It’s built my self-confidence. I feel more empowered to heal.” “[It was empowering] when the group decided completely, on their own, and it was phenomenal, all the questions for the different animals. They got to do that. We actually got to do it.”*

Time spent doing something productive was valued by the participants. They believed that they had invested their time in a way that would lead to positive outcomes for the community through the educational tool developed. *“[It’s]...a phenomenal project that finally came together in that short a period of time, there’s no other word for it but phenomenal.”*

A further issue that some participants identified as a benefit in the session evaluation forms regarded the access to good food and drinks. The provision of good quality food and fruit juices was a core part of the project design that was appreciated by the participants and enhanced the experience of being part of the group.

Process Issues

Aspects the participants enjoyed

The SAP participants appreciated the opportunity they were given to take on a leadership role within the group; however, they also mentioned that it was good that they were not required to take on a leadership role in the group sessions. Such a requirement would have placed too much pressure on those who did not feel comfortable in doing so.

An aspect of the process that was cited as a positive element was the discussion of risk-taking that took place at the beginning of the group process. Participants spoke positively about the manner in which the facilitators had explained risks, what they are, and how or whether to engage in risk-taking in the sessions.

The participants valued the process of reviewing the respect chart at the beginning of every meeting. The time taken to review the ground rules, including confidentiality issues, touching, and respecting others’ opinions was seen to be important.

The participants liked having both a male and a female facilitator present. The male facilitator was described as being gentle and as providing a male perspective in an appropriate way. It was accepted that the facilitators would take the lead in group sessions at times. This was seen as natural, “the norm” or a requirement of fulfilling the job of facilitator. Appreciation was expressed for the work of the facilitators. *“We should all be grateful to each other and to ourselves [and] to the facilitators”.*

“[Addressed to a facilitator at the end of the program] Thank-you! For your acceptance, patience and understanding. Is it possible, that you might bottle those virtues, and place it, with the instruction manuals, for those teachers? A lot of them might need it, when they start hearing some children/teens, disclosures!”

The participants liked elements incorporated into the process as motivators or ice-breakers, including the games, brainstorming activities, silly prizes, and stickers. In addition, the location used for the Social Action Project program was described as being appropriate in that it was central, on bus route, convenient or within walking distance of housing.

Concerns expressed about the process (areas for further development)

By far, positive comments outnumbered negative statements about the group process. However, some participants mentioned that they did not like the feeling of being self-conscious, anxious or nervous at the beginning of the project. This feeling was heightened for some participants when playing games in the early sessions. Nevertheless, it was stated that, gradually, with support from the facilitators, they became comfortable with the games. This was acknowledged to be due to the skill of the facilitators.

A concern was noted regarding certain aspects of the facility in which the sessions were held. Some participants were upset about a perceived lack of privacy in the meeting space since, at times, other people in the building were seen or heard going in and out of other rooms or appearing in the doorway of the room in which the SAP sessions were being held. In addition, it was noted that the arrangement of the furniture within the meeting room was an important factor impacting on feelings of safety for participants (e.g. seating arrangements in relation to the walls and doors).

Given the value placed on the social support dimension afforded by the SAP group, it may not be surprising that some participants stated that they would have liked to have had more informal, unstructured time within the group to enable them to chat with each other. On the other hand, some participants wanted to have more time to complete the structured activities of the group.

Another area for further development pertains to stress management. Given the issues and needs of the target population in the program, some participants experienced considerable stress or anxiety with regards to the demands of completing an action project. The stress reactions were more intense when there were setbacks in project development. Therefore, it is important to incorporate strategies of self-care and stress management into the program.

Whoa! I felt like Dorothy and Toto when their house was in the air. Whirlwind! I left asking myself "what the heck was that?" "Stressed-confusion". Time line for project overwhelming. We are already behind!!

It is notable that many participants remarked on their high levels of stress or anxiety when setbacks occurred but later were grateful for the opportunity to continue with the project and to see it through to completion. They commented that it was empowering to be part of a successful project. The benefits of participation in the project outweighed the challenges experienced when working through difficulties in the project development phase.

Regrets or challenges

Some of the participants mentioned that they regretted that they themselves had engaged in specific inter-personal interactions or communication patterns which they felt may have disrupted the group. Examples of such behaviours are interrupting others, being too demanding or bossy or, alternatively, being too quiet and withdrawing from discussions. It was also noted that some behaviours of other participants were not helpful to the process, but also, it was important to note that certain behaviours were used as coping strategies and therefore were necessary. *“I found it really difficult if the group was going on if people were doing other things besides just group things, whether it be knitting or reading a book or whatever. I found it distracting. And yet I know, for some, it’s coping skills. So you have to make allowances”*.

As was noted above, a number of participants had to miss some sessions due to other commitments or obligations and this was cited as a regret. Participants believed that there should have been some provision for extending the group time within a session if it was going well and that it should have been possible to extend the number of sessions. *“...flexibility is needed because some cannot focus for longer than two hours on some days.”*

Due to time and funding constraints, the facilitators had to complete some group tasks or make decisions about the project without the involvement of the participants. Some participants mentioned that there should have been greater flexibility in the SAP group process to enable the participants to be involved in all aspects of the project.

Discussion within the group of the experiences of various participants with sexual assault and mental illness acted as triggers for some group members. This was cited as both a challenge and as a strength of the group process. *“I didn’t expect to be triggered. I didn’t anticipate the emotional triggers or reacting to other peoples’ emotions. And working with any group of new people is challenging.”*

CONCLUSIONS

The Social Action Project program was seen to be successful by the participants. They were extremely pleased, even elated, with the successful outcome evidenced by the production of the puzzle and the media coverage of the unveiling of the resource. As noted above, the participants experienced some challenges in the process of the 12 week program; however, they believed that it was worth the struggle to have the opportunity to be part of a project that successfully produced an educational tool which had the potential for addressing the issue of sexual assault among children and adolescents.

The current program has documented the steps required to develop and offer a similar program by other organizations. The resources produced by *Bridging the Service Gap* ensure that other groups do not have to “reinvent the wheel” in order to provide this type

of service to people who have experienced sexual trauma and mental illness. Future Social Action Project programs should follow the guidelines developed and outlined in the Social Action Project manual developed from the current project. In particular, because of the vulnerable target population, it is essential to staff these programs with well trained facilitators who are experienced in working with people who have experienced sexual trauma and mental illness.

RECOMMENDATIONS OF THE PARTICIPANTS

- 1) Ensure that facilitators are aware of and prepared to address the various ways in which the participants' emotional and mental health issues must be considered and dealt with at every stage of the project.
- 2) Build in strategies to ensure that participants do not feel stressed by the requirements of completing a "high pressure project".
- 3) Consider how the timeframe/timelines can be more flexible to take into account the needs of the participants.
- 4) Develop strategies by which the facilitators can provide "reality checks" to rein in the enthusiasm of the group without undermining the goal of creating a process that is empowering to the participants. One possibility is for the group to envision a larger project and to decide on one phase of it that can be completed within the budget and timelines established for the group.
- 5) Explain the budgetary limitations to the participants at the beginning of the project.
- 6) Develop strategies to deal with the inevitable absences, for as long as several weeks, of some group participants. If possible, recruit a larger number of participants at the beginning of the project in order to take into account attrition or absences.
- 7) Explain to the participants that the very nature of the Social Action Project process requires that the facilitators may be having to develop materials and project plans at the last minute and "flying by the seat of their pants" to develop the project (i.e. since it is a relatively unstructured group process guided by the participants themselves).
- 8) To the greatest extent possible, arrange furniture in a way that addresses the safety issues of participants and develop strategies for dealing with human movement within the building in order to minimize disruptions, distractions and fears among participants.

- 9) Put into place a project advisory committee comprising men and women who have experienced sexual trauma and mental illness in order to determine how men may be recruited as participants into Social Action Project programs.

REFERENCES

- Bellamy, C.D. & Mowbray, D.T. (1998). Supported education as an empowerment intervention for people with mental illness. *Journal of Community Psychology*, 26(5), 401-413. [On line] Academic Search Premier.
- Bennet, B. 2003. *Mental illness: a guide to recovery*. Self-published.
- Corrigan, Patrick W. 2002. "Empowerment and serious mental illness: treatment partnerships and community opportunities". *Psychiatric Quarterly*. Vol. 73(3).
- Crowder, A. 1993. *Opening the door: a treatment model for therapy with male survivors of sexual abuse*. Family and Children's Services of the Waterloo Region. National Clearing House on Family Violence. [On Line]
- Davidson, L., Stayner, D.A., Nickou, C., Styron, T.H., Rowe, M. & Chinman, M. L. Simply to be let in: inclusion as a basis of recovery. *Psychiatric Rehabilitation Journal*, Vol. 24(4). [On line] Academic Search Premier.
- Everett, B., Adams, B., Johnson, J., Kurzawa, G., Quigley, M., Wright, M., & Pape, B. (2003). *Recovery rediscovered: Implications for mental health policy in Canada*. Canadian Mental Health Association.
- Gardner, F., Lehmann, J., Brown, G. & Brooks, M. 2005. Noticing change: developing strength-based tools in a mental health service. *Australian Social Work*. Vol. 58(1). [On line] Academic Search Premier.
- Herder, D.D. (1991). The treatment of childhood sexual trauma in chronically mentally ill adults. *Health & Social Work*, 16(1). [On line] Academic Search Premier.
- Hess, R.E., Clapper, C.R., Hoekstra, K. & Gibison, F.P. (2001). Empowerment effects of teaching leadership skills to adults with severe mental illness and their families. *Psychiatric Rehabilitation Journal*, 24(3), 257-265. [On line] Academic Search Premier.
- Mazelis, Ruta. "Collaboration in instrument design: working together to better understand". *The Tapestry*. Women, Co-Occurring Disorders and Violence Coordinating Study. Substance Abuse and Mental Health Services Administration's Centre for Substance Abuse Treatment, Center for Mental Health Services and Center for Substance Abuse Prevention.
- Moses, Dawn J. 2001. *Innovations from the sites*. Women, Co-Occurring Disorders and Violence Coordinating Study. Substance Abuse and Mental Health Services

- Administration's Centre for Substance Abuse Treatment, Center for Mental Health Services and Center for Substance Abuse Prevention.
- Mowbray, Carol T., Robinson, E.A.R., Holter, M. 2002. "Consumer drop-in centers: operations, services and customer involvement". *Health & Social Work*. Vol. 27(4)
- Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C. & Fox, L. (2002). Recovery from severe mental illness: an intrapersonal and functional outcome definition. *International Review of Psychiatry*, 14, 318-326. [On line] Academic Search Premier.
- Olney, M.F., & Kim, A. (2001). Beyond adjustment: integration of cognitive disability into identity. *Disability & Society*, 16 (4), 563-583. [On line] Academic Search Premier.
- Provencher, H.L, Gregg,R., Mead, S. & Mueser,K. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 26(2). 132-144. [On line] Academic Search Premier.
- Townsend, W. & Glasser, N. Coping with. *Psychiatric Rehabilitation Journal*. [On line] Academic Search Premier
- Vaa, G., Egner, R. & Sexton, H. (2002). Sexually abused women after multimodal group therapy: a long-term follow-up study. *Nord J Psychiatry*, 56(3), 215-221. [On line] Academic Search Premier.
- Wallis, Denise A. Nisbet. 2002. "Reduction of trauma symptoms following group therapy". *Australian and New Zealand Journal of Psychiatry*. Vol. 36.
- Young, A.S., Forquer, S.L., Tran, A, Starzynski, M. & Shatkin, J. (2000). Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness. *The Journal of Behavioral Health Services & Research*, 27(3), 321-333. [On line] Academic Search Premier.