

# Report on Bridging the Service Gap For Sexual Assault and Mental Illness Survivors

A Summary Report

by

**Denise McKinlay, M.S.W, RSW**  
Lead Researcher and Project Coordinator

**Carol Kauppi, PhD**  
Co-investigator and Associate Professor  
School of Social Work, Laurentian University

Prepared for  
**Ministry of the Attorney General**

Prepared by the  
**Sexual Assault Survivors' Centre Sarnia-Lambton**

July 2005

# **Summary Report**

## **Bridging the Service Gap for Sexual Assault and Mental Illness Survivors**

by  
Denise McKinlay, M.S.W., RSW  
Carol Kauppi, PhD

This study was funded by Ministry of Attorney General  
"Community Capacity Building" Grant

Additional copies of the report may be obtained from the

Sexual Assault Survivors' Centre Sarnia-Lambton  
118 Victoria Street North  
Sarnia, Ontario  
N7T 5W9

Tel. (519) 337-3154  
Fax (519) 337-0819

Email [sascs1@ebtech.net](mailto:sascs1@ebtech.net)

The entire report may also be viewed on the web site:

[www.sexualassaultsarnia.on.ca](http://www.sexualassaultsarnia.on.ca)

## ACKNOWLEDGEMENTS

The support, time and contribution of many people ensured the success of this project. Local service providers, front-line staff, managers, volunteers, faculty members and volunteers assisted in many phases of this study. Thank you to the many residents of Lambton County who chose to participate in the study and who shared their personal experiences so that others may be helped.

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. A special thank you is extended to the staff of the Sexual Assault Survivors' Centre Sarnia-Lambton who spent many hours in the initial phases of the study assisting with the chart review and subsequent pilot focus groups.

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

- Addiction Services
- Sexual Assault/ Domestic Assault Treatment Centre
- Lambton College
- St. Clair Catholic District School Board
- Consumers' Survivors Association of Lambton
- Big Sisters
- Probation & Parole Services
- Reseau de Femmes
- Victim Witness Assistance Programme
- Aamjiwnaang First Nation
- North Lambton Community Health Centre
- St. Clair Child & Youth Services
- Family Counselling Centre
- Women's Interval Home
- Canadian Mental Health Association
- Inn of the Good Shepherd & The Haven
- Sarnia Police Services
- Victim Services
- Lambton Family Initiative

## EXECUTIVE SUMMARY

The first year of this three-year study has identified the gaps in services for people with a mental illness and, unlike other recent studies, this report has examined underlying issues regarding sexual abuse/assault and the need for services in Lambton County that can address these issues. The connection between sexual trauma and moderate to severe mental illness has been studied extensively in the current literature; it is clear that recovery and improved quality of life are dependent on addressing both these issues. 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). It is important that political, social, organizational and community action be taken to remedy the barriers to existing services and the gaps in services that have been known to our government and the professional community of service providers for some time.

This study was conducted between August 2004 and June 2005 and the first step was an internal review of the Sexual Assault Survivors' Centre Sarnia-Lambton. It included a review of the files for a one year period, a private interview with the executive director, a focus group with front-line staff and, after approval by an adhoc ethics review committee in Sudbury, a pilot focus group with service participants. Data collection then took place in the form of focus groups and personal interviews with a broad range of service participants from diverse local organizations. The focus groups and interviews were audio-taped and transcribed verbatim. 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 current 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.

## RESULTS

### *Strengths of Existing Services*

- A wide range of programmes are available to address the practical needs, crisis needs, support systems and social needs for the SMI population.
- Professional skills and knowledge of service providers.
- Service participants' strategies and abilities to access services.

### *Problems with Existing Services*

- Service delivery: limited publicly funded counselling services, long waiting lists, programme cuts, limiting criteria for services, fee for service, difficulty in gaining admission to psychiatric ward at hospital, poor coordination of services.

- Service providers: little counselling available from psychiatrists, lack of understanding and sensitivity to issues surrounding sexual abuse/assault and mental illness, poor knowledge of community resources, deficient counselling skills and personal qualities that were perceived as judgmental and officious, sexual misconduct by service providers.

### ***Barriers to Existing Services***

- “Red tape”, confusing paper work and inability to meet criteria for service
- Practical barriers: lack of transportation, telephone, child care, inability to access services during regular office hours, fee for services.
- Service participants’ compromised abilities: poor communication skills, being hampered by symptoms of mental illness, feeling fearful, issues related to age.
- Stigma: internalizing stigma, the public’s fears, service providers’ attitudes towards people with mental illness, service providers poorly trained to handle the issues.
- Community concerns: inadequate housing and an increased risk to personal safety.
- Lack of family support or active interference by family members.

### ***Barriers to Reporting to Police***

- Attitudes of legal professionals: myths and stereotypes.
- Fear of: reprisals by perpetrator, rejection by family/peers, public shaming, being blamed for the assault, breaking the “code” of the streets, retelling the story.
- A perception of revictimization by court process.

### ***Gaps in Services***

- Formal and informal support systems.
- Advocacy services: professional and peer advocacy.
- Therapeutic programmes: communication and social skill building, relationships, educational, cognitive-behavioural groups, trauma programmes, groups for family members, psycho-educational groups.
- Further services required: youth programmes, practical skills (budgeting), peer partnering programmes, eating disorder programmes, services for men.
- Residential programmes: treatment focus (addiction, detoxification, sexual abuse, trauma), shelter (formal shelter system).

### ***Participants’ Recommendations for Change***

- Community collaboration: case management system, collaboration with medical community, formal networking process, community resource manual.
- Coordination of programmes for volunteer service participants: resources, media interviews, school programmes, public education.
- Education, awareness and training for public, professionals and service participants.
- Government and legislative changes: increase funding to organizations and agencies, increase minimum wages, increase Disability and Ontario Works income, invest in adequate low-income housing
- Developing and implementing programmes at the community and organizational level: outreach programmes, advocacy, formal and informal support systems, therapeutic programmes

## **BRIDGING THE SERVICE GAP FOR SEXUAL ASSAULT AND MENTAL ILLNESS SURVIVORS**

### **INTRODUCTION**

The first year of this three-year study has identified the gaps in services for people with a mental illness and, unlike other recent studies, this report has examined underlying issues regarding sexual abuse/assault and the need for services in Lambton County that can address these issues. The connection between sexual trauma and moderate to severe mental illness has been studied extensively in the current literature and recovery and improved quality of life are dependent on addressing both these issues. In Lambton County, one out of five residents (26,000) will experience a mental illness during their lifetimes (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). It is important that political, social, organizational and community action be taken to remedy the barriers to existing services and the gaps in services that have been known to our government and professional community of service providers for some time.

This study was conducted between August 2004 and June 2005 and the first step was an internal review of the Sexual Assault Survivors' Centre Sarnia-Lambton. It included a review of the files for a one year period, a private interview with the executive director, a focus group with front-line staff and, after approval by an adhoc ethics review committee in Sudbury, a pilot focus group with service participants. Data collection then took place in the form of focus groups and personal interviews with a broad range of service participants from diverse local organizations that were audiotaped and transcribed verbatim. 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 current 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.

### **RESULTS OF INTERVIEWS AND FOCUS GROUPS**

This report has generated recommendations directly from service participants and it has identified and prioritized the needed changes according to their perceptions. Input from front-line workers and managers of agencies and organizations providing services to the community have highlighted their concerns and constraints when providing services and some of the differences in perceptions regarding the needs of this population.

Participants in the current study were invited to share their recommendations for service improvement in Lambton County. They spent time expressing their views on the strengths of the existing services and how they thought the quality of those services could be enhanced. There was recognition that the agencies and front-line workers were doing everything in their power to assist all service participants and that the major block to better-quality and more extensive programmes came from either government cut-backs in funding or from little or no increase in funding over many years despite the downloading of programmes onto the community agencies and organizations.

Both service participants and service providers were asked questions regarding the strengths of the existing service systems, possible problems within the system and barriers for service participants trying to access services. Service participants and service providers were also asked about possible gaps in service provision in Lambton County and they were encouraged to create a “wish list” of services that would benefit people who have been sexually abused or assaulted and who also have a moderate to severe mental illness.

Specific to the issues of sexual assault and historical sexual abuse, service participants and service providers were asked to identify the barriers that stopped people from reporting sexual assaults to the police. They were also invited to identify risk factors for sexual assault and what they thought would help decrease people’s vulnerability to sexual assault and sexual abuse. Also, they discussed what would assist people to disclose sexual abuse or sexual assaults so that they could receive assistance.

The categories and subcategories that emerged from the study (see Table 1) supported studies on mental illness that have been conducted in Lambton County or Ontario but several interesting and unique ideas for programmes were mentioned.

The interviews and focus groups with service participants and service providers created two separate systems of analysis concerning the study’s objectives and they have been compared and contrasted under each category. The following tables show the results in the form of

- The percentage of total number of people interviewed in each category: service participants 40, service providers 68.
- The actual number of respondents that discuss the topic.
- The number of times this topic was discussed by respondents.

Table 2 shows the main categories that were discussed by the participants in each respondent group. Recurring themes under different category titles raised by a majority of the participants indicate areas of focus for the development of programmes to address the needs of the study group. Categories were deemed to be major themes when 60 percent or more of the participants in either the respondent group discussed the topic.

**Table 1. Themes and Categories from Study Questions**

Main Study Themes	Categories	Sub Categories
<b>I. Strengths of Services</b>	Individual Organizations	- Practical Assistance - Therapeutic Programmes - Crisis Services - Support Services - Social Connections - Environment within Services
	Agency Staff Members	- Professional Knowledge & Skills - Personal Qualities
	Strengths & Abilities of Service Participants	- Participant Strategies - Participant Informal Supports
<b>II. Problems with Existing Services</b>	Service Delivery	
	Service Providers	- Skills & Knowledge - Knowledge of Resources - Sexual Misconduct
<b>III. Barriers to Accessing Existing Services</b>	Barriers Within Existing Services	
	Service Provider Staff	
	Practical Barriers	
	Client Abilities	- Youth Abilities
	Stigma	- Professional Attitudes - Internalized Stigma
	Community Concerns	
	Lack of Family Support	
<b>IV. Barriers to Reporting to Police</b>	Attitudes of Legal Professionals	
	Fear	
	Revictimization by Court Process	
<b>V. Gaps in Service Provision</b>	Support Systems	- Formal Support Systems - Informal Support Systems
	Advocacy Services	
	Further Service Required	- Youth Programmes - Peer Partnering Programmes - Eating Disorder Programmes - Services for Men
	Therapeutic & Educational Grps.	
<b>VI. Decreasing Vulnerability to Sexual Assault/Abuse</b>	Residential Programmes	- Substance Abuse Treatment & Detoxification Centre - Residential Treatment Centre (Sexual Abuse) - Formal Homeless Shelter System
	Public Education & Awareness	
<b>VII. Assisting Disclosures of Sexual Assault/Abuse</b>	Professional and Public Education & Awareness	

**Table 2. Comparison of the Percentage of Service Participants and Service Providers Discussing Each Major Category**

<b>MAJOR CATEGORY</b>	<b>SERVICE PARTICIPANT<sup>a</sup></b>	<b>SERVICE PROVIDER<sup>b</sup></b>
	<b>Percentage of Respondents (%)</b>	
<b>STRENGTHS</b>		
Strengths of Service System	83	93
Strengths of Staff	73	65
Staff's Personal Qualities	83	13
Strengths and Abilities of Service Participants	88	15
<b>PROBLEMS</b>		
Problems with Service Delivery	53	93
Problems with Staff	75	70
<b>BARRIERS</b>		
Barriers in Existing Services	78	63
Barriers with Staff	78	43
Practical Barriers	43	41
Barriers – Client Abilities	73	90
Barriers – Stigma	73	93
Barrier- Community Concerns	25	19
Barrier – Little Family Support	73	90
<b>BARRIERS TO REPORTING</b>		
Barrier- Attitudes of Legal Professionals	60	43
Barrier – Fear	28	37
Barrier – Revictimization in Court	45	29
<b>GAPS IN SERVICES</b>		
Formal Support Systems	65	82
Informal Support Systems	76	63
Advocacy	28	36
Further Services	63	93
Therapeutic/Educational Groups	25	25
Residential – Treatment and Shelter	23	28
<b>DECREASE VULNERABILITY</b>		
Education and Awareness	45	32
<b>ASSIST DISCLOSURES</b>		
Education and Awareness	45	35
<sup>a</sup> Percentage of service participant sample that identified and discussed this theme.		
<sup>b</sup> Percentage of service provider sample that identified and discussed this theme		

Service providers were required by service participants (73%) to have a good understanding of issues around mental illness and sexual abuse/assault, violence and other issues. The gap between the number of service participants (83%) and the service providers (13%) who identified the personal qualities of staff as an important theme was very large and may indicate that workers undervalue the importance of their intrinsic supportive qualities. Out of the 13 percent who did discuss this theme, most of them were upper management describing the qualities they thought most effective in their workers. The personal qualities of staff members in any organization are important, not only for the smooth operation of the agency, but also to ensure that the connections with service participants are strong and supportive. If service participants are not engaged in a relationship in which they feel validated and empowered, no service or programme will assist them to make changes.

Service participants' strengths and abilities were strong themes in the interviews with service participants but again this was an area where there was a significant disparity between the number of service providers (15%) and service participants (88%) who identified this theme. The service participants discussed the importance of using their skills and strategies to benefit others and how important this is in bringing a sense of meaning to their lives. The theme of helping others ran powerfully through every interview indicating that this aspect should be incorporated in interventions for this population. Although many service providers strive to be strengths based, there is a tendency to identify the service participants' problems and deficits and then attempt to find the right programme or intervention to assist.

When barriers to accessing services were discussed, service participants' restricted abilities to seek services were discussed by service participants (73%) and service providers (90%). It was recognized that mental illness symptoms combined with the sequelae of sexual abuse/assault, the effects of poverty, discrimination, violence and past victimization impact on a service participant's ability to access services. For some, a family, peer or community culture and worldview involved norms that prevented the disclosure of sexual abuse or mental illness. These norms had to be followed or else they were at risk for expulsion from their place in their own society and this, too, could act as a barrier to seeking services.

The largest number of suggestions pertained to the need for adequate funding for the existing publicly funded services so that trained and experienced staff could be hired and programmes and services that have been cut over the years could be reinstated. An increase in the publicly funded counselling services available for the severe and moderately mentally ill was considered the most pressing need among many. Adequate funding for those services that were available would address the long wait lists and provide services in a timely fashion when the need is the greatest.

Insufficient government funding has produced a community service atmosphere that is sometimes competitive and protective in nature. Fear of funding cut backs or possible removal of all funding due to the dreaded words "duplication of services" has forced organizations and agencies to focus and specialize on specific service delivery with

clearly marked boundaries despite the multiple needs of service participants. As service providers narrowed their focus for interventions, service participants have been denied access to participate in certain services based on factors beyond their control: the circumstances and/or characteristics of potential participants that have been the basis for exclusion included the severity of their mental illness diagnosis, poverty (inability to pay for services), perpetration of sexual or physical violence and intellectual disability. Exclusionary practices have raised the issues of discrimination and human rights violations.

The service needs of people who have experienced sexual abuse and/or sexual assault and who have a mental illness (diagnosed or undiagnosed) range on a continuum based on the severity of their symptoms and the impact they have on each person's functioning and quality of life. Mental illness or symptoms of mental illness can vary from mild (stress, anxiety), to moderate (MMI) (depression, personality disorders, PTSD) to severe (SMI) (schizophrenia, bipolar). Both the MMI and SMI population shared a sense of discrimination based on their mental health issues. They felt that many professional service providers were reluctant to provide service because they lacked training and knowledge concerning mental illness. Education and training for legal professionals and service providers on issues concerning mental illness, sexual abuse and sexual assault was considered of primary importance as they needed up-to-date information on the latest treatments, medications and an increased sensitivity to these concerns. It was felt that increased education of these matters with the police and legal professionals could encourage people to report sexual abuse and assault.

Many counsellors, social workers and other service providers felt very competent within their particular field of practice but were not as comfortable with some of the intensive issues the study population often were experiencing. No organization or agency front-line staff that participated in the interview process felt they were adequately prepared to address all service participants' service needs. Yet, most agencies and organizations did not feel they were financially able to provide training opportunities for their staff members on a regular basis. The study populations of MMI and SMI service participants who have a sexual trauma history often have multiple and pressing needs that necessitates concurrent interventions or they tend to go from crisis to crisis. The "big three" sexual trauma, mental illness and substance abuse need to be addressed in concert as focusing on the sexual trauma can create an increase in the severity of the other two. In order to be able to provide this type of service, front-line workers need constant training to keep updated in their primary fields while accessing cross-training in other disciplines. With a core understanding of sexual abuse, mental health problems, psychotropic medications and addictions issues, workers are better able to identify early warning signs when something is amiss and an appropriate referral or intervention can take place before a crisis arises.

One of the most discussed topics with service providers (93%) concerned the limited community resources to support clients who were in crisis. The crisis lines are available and the CMHA crisis team can be accessed 18 hours of the day. Yet, the most important part of any service participant's safety plan created with their worker was to go to the

hospital if they were suicidal. Unfortunately, this important resource, due to funding restraints, has limited beds available on the psychiatric ward and it is no longer able to respond to the community's needs. Many service participants (53%) spoke of the difficulty of getting admitted to the ward when they felt at risk. Youth found it particularly difficult to gain hospital admission. Participants felt the loss of the outpatient day programme at the hospital and said that, after discharge, there were few if any supports available if they had a moderate mental illness. The lack of psychiatric support has led many agencies and front-line workers to reduce their intensive trauma work with service participants as they are not able to monitor service participants' medications, do not have access to psychiatric consultations or ongoing support. As noted, service participants are rarely able to gain admittance to the psychiatric ward when they are in crisis. Many service providers expressed concern whether it was ethical to address the serious concerns of trauma survivors who have a moderate to serious mental health problem under these conditions. Managers of organizations spoke of concerns regarding liability, as they were working with a population with high needs and the front-line workers did not have the training to address the trauma, the mental illnesses and other issues. Workers were trained according to the mandate of each particular agency.

Of serious concern and identified as a severe block to service provision to the MMI and SMI population was the lack of support from and coordination with the medical system and other agencies. The doctor shortage in Lambton County and long waitlists to access psychiatric services has effectively blocked service providers from mental health supports that would assist them in providing service to this population. This has further hindered the service providers' abilities to render appropriate and timely service to this population as, without medication, many people may not be able to remain stable while involved in trauma counselling, the court process or any high stress situations.

Without a coordinated team approach that includes mental health agencies, the medical community, counselling services as well as any other involved services, it is difficult to provide stability and safety. Service participants stated that improved coordination of services when more than one service provider was assisting a service participant was considered a necessary improvement in the system of service delivery. Service participants with multiple needs and issues are presently placed in a position where they have to seek services at different agencies but the agencies, due to funding restraints, lack the staff and time for adequate service coordination.

To address this common problem, many service providers also discussed the need for collaboration between service providing agencies and increased coordination of services through a case management system. To a limited extent this was happening between agencies though on an informal basis. Front-line workers built informal connections between service providers. Formal collaboration can be a very slow process, as it requires changes in boundaries, policies, mandates as well as the development of protocols, permission from funding sources as well as boards. Coordination and collaboration revolves around myriads of practical concerns; the key issues being concerned with which agency will take the case management responsibility for high-need

and high-risk service participants. This is a resource (time, money, staff) and liability issue.

Also, when systems of service provision are different in structure, treatment philosophy, approaches, funding streams and workers have different educational and experiential backgrounds, the coordination of services across multiple service systems is often difficult and can produce tension between disciplines (Brown, Grella, Cooper, 2002). Yet, a case management system has been found to be highly effective with service participants with a sexual trauma history as the long-term effects can seriously disrupt adult functioning in multiple areas of their lives (Herder, 1991).

Many service participants (75%) reported that they relied on their service provider to have knowledge about what community resources were available to assist them as they did not know a centrally located information centre with these details. Service providers found difficulty in keeping up-to-date with the programmes and services that were in Lambton County and the criteria for admission into a programme. The development of a web site and hard copy resource guides listing all programmes (formal and informal) that would be kept current was considered vital to service participants and service providers.

Of great concern were accounts of sexual misconduct by service providers that had either not been reported or had been handled privately within an organization or agency. Service participants interviewed for this study were not asked about sexual misconduct yet 10 percent voluntarily shared these experiences when discussing problems within existing services. As studies have shown, people with sexual abuse histories who also have a mental illness are extremely vulnerable to further sexual exploitation and it is deeply concerning that people have been revictimized by service providers in Lambton County. None of the service participants who shared experiences of sexual victimization felt able to pursue the matter with police or professional organizations. Many felt their psychiatric diagnosis had been used to discredit their complaint.

The barriers to accessing existing services were issues for all service participants and generated a great deal of discussion. Some of the practical barriers could be addressed by service providers with minor adjustments, by the reallocation of funds or with an increase in funding. Limited income, lack of permanent residence, transportation, telephone, identification, Ontario Health card or child care as well as language barriers, age, disabilities were all problems quickly identified by service participants (43%) and service providers (41%). The psychological sequela of sexual trauma affects many areas of service participants' lives and interventions to assist often require long-term counselling. Very few publicly funded services were able to offer long-term counselling due to funding restraints. Cultural differences were also identified as a barrier to existing services as services were delivered according to mainstream culture's definition of mental illness and interventions were designed to fit with the values and worldviews of the governing society. Another barrier to the delivery of appropriate services concerned addiction issues. If someone had a severe substance abuse problem, it could prevent him or her from accessing many services. Some counselling services required that the addiction issues be addressed before engaging in counselling. Other services found that

severe addiction problems created problems in their organization and were difficult to manage. As Sarnia has limited addiction services, no detoxification centre or residential treatment, a substance abuse problem can be a very real barrier for participants. Other barriers (lack of physicians, homelessness, low income on social assistance) can only be overcome as a result of lobbying all levels of government to address the issues.

Sexual assault and mental illness are still very powerful stigmas in our society and service participants (73%) and service providers (93%) recognized the impact this has on service participants. The result is that a person who has experienced sexual abuse and /or sexual assault and who has a mental health problem feels a great deal of personal shame about events over which he or she has no control and with which he or she shoulders no blame. When participants living with these experiences also have addiction problems the sense of shame and stigma increases. If they have also been incarcerated or are on probation, they find further difficulty in accessing services. The internalized stigma and shame make it very difficult for people to decide to access services in our community and, when they are able, it behooves us to ensure that publicly funded services are available in a timely fashion.

Service participants (78%) reported that they had encountered service providers who were uncomfortable working with these issues. Some participants mentioned contact with legal and counselling professionals who appeared intimidated or frightened of them. Service participants' credibility was questioned about medical issues and about criminal victimization. Service participants mentioned times when police did not respond to a call for assistance. Professionals who were living with a mental illness and a sexual trauma history stated they were fearful of sharing this information with colleagues in the event that they would be perceived negatively or they would lose their professional credibility.

To reduce the stigma around sexual abuse/assault and mental illness and to decrease people's vulnerability to sexual assault, most participants suggested a comprehensive media approach to public awareness and education. It was suggested that people who had or were experiencing these issues may want to do public speaking in the schools and share their stories in newspaper articles. This was perceived as the most informative and engaging method of drawing the public's interest and presenting a very human face on the issues. Participants also saw a role for professionals in these fields speaking on the issues in public forums.

Several gaps in services were identified by service participants and service providers. The factor most frequently discussed and the major theme concerned social isolation and the need for formal and informal support systems that would provide a safe environment for social interactions of peers. The experiences of sexual abuse/assault and living with symptoms of mental illness often had a negative impact on a person's ability to connect with and trust others. Participants wanted to be able to interact with others who shared and understood their experiences. Service participants (65%) and service providers (82%) discussed the importance of formal supports that were organized and facilitated by professional agencies and organizations. More service participants (76%) were focused on informal supports than the service providers (63%) who had concerns about the safety

and quality of informal supports. Informal supports were described as being peer support groups, family or friends and they were considered helpful and supportive by participants. Many felt that the combination of both informal and formal supports would provide stability, alleviate the sense of isolation, reduce hospital admissions, reduce the need for long-term service and frequency of interventions and assist participants to improve the quality of their lives. The absence of formal and informal supports could have a direct negative impact on their lives. Service participants involved in the criminal justice system could remain incarcerated instead of being released on bail (as are their mentally health counterparts) if they were considered at risk due to lack of supports.

Advocacy was identified as important in assisting people to navigate the social service system, school system, government programmes, medical system and within the legal process. Service participants (28%) recommended that agencies train their staff in advocacy techniques and allow time in their schedules to accomplish this. They suggested that informal systems be developed in the form of peer advocacy within agencies and organizations. Service providers (36%) saw the need for advocacy on two levels; one step concerned lobbying the different levels of government for changes in legislation and policies and another step involved advocating with community social, legal, educational and medical services.

A dearth of publicly funded programmes for the issues of sexual abuse/assault, mental illness and addictions was considered problematic. Service participants (63%) requested therapeutic programmes, youth programmes, peer partnering programmes, eating disorder programmes and services specifically for men. The most frequently requested group dealt with communication and relationships building skills as many people felt they lacked the ability to connect with others and this had increased their sense of isolation and poor self-image. Although one may have expected that a higher percentage of the service participants would request further services, many people wanted services that were already available in Lambton County but that they were unable to access due to long waiting lists, lack of money, transportation issues, childcare concerns and limited admission criteria. Service providers (93%) identified a need for outreach service services for seniors, the homeless and aboriginal communities. The barriers of stigma, transportations costs, fear and anxiety about going to a new agency would be alleviated if outreach services could be arranged. Another concern for both service participants and service providers concerned the lack of community support services for people upon discharge from the psychiatric ward of the hospital.

Service participants (23%) and service providers (28%) also saw a need for residential treatment for substance abuse with psychological and physiological programmes. A formal shelter system would provide safety, easy access to services and reduce the sexual exploitation of homeless youth and women. As substance abuse and homelessness increases people's vulnerability to sexual abuse/assault, participants stated that the funding of a shelter system and residential treatment programmes (sexual abuse and addiction) are needed. Also mentioned was a long-term housing shelter for youth that would teach life skills to teens and give ongoing support rather than encouraging them in independent living.

The main theme that emerged concerning problems in service provision by front-line workers was identified by service participants (78%) as a deficiency of knowledge about the issues surrounding mental illness and sexual abuse that led to a poor relationship between service providers and service participants. Many respondents stated that their service providers did not know how to respond to their disclosures and lacked information and suitable resources about the issues. Increased sensitivity regarding receiving disclosures and training about appropriate and knowledgeable interventions was needed.

Participants suggested that teachers, parents, coaches, ministers and other authority figures should be trained on how to encourage and receive disclosures of sexual abuse and the procedures they then needed to follow. To reduce a child's vulnerability to sexual abuse, parents could be taught how to build their children's safety skills, children could be taught in school based programmes about danger signals and appropriate responses and adults and teens could be taught safety strategies and the legalities.

Many service participants (45%) recognized their own vulnerability to sexual abuse or assault as the result of homelessness, poverty, addictions, mental illness and a sexual trauma history. Without a sense of safety, it is very difficult for people to heal and manage their mental health symptoms. Substandard living accommodations and homelessness compromises their safety and is a barrier to recovery. To reduce vulnerability, it is important that the community invest in low-income housing that is safe, affordable and placed throughout the community rather than centred in less desirable and unsafe areas of the city. The developmentally delayed population with a trauma history and mental illness are vulnerable to further abuse as they are sometimes very dependent on families and caretakers and may never have been allowed to say "no" or to voice their opinions or insist that their needs be respected. Decreasing the vulnerability for this population depends on education for the developmentally delayed but also for their families so they understand how to manage the issue of sexuality and support their family member in learning safety skills.

During the analysis, several themes emerged in regard to reporting sexual abuse/assault to the police. Service participants (60%) stated that the attitudes of legal professionals (based on myths and stereotypes) discouraged them from continuing with the process. Several participants (28%) reported that fear of reprisals, fear of family reaction, public shaming, being blamed and breaking "the code of the street" often stopped them from initiating the first step of talking to someone about reporting. Some respondents (45%) mentioned the potential to be revictimized by the court process was sufficient reason not to report sexual assaults or sexual abuse to the legal authorities. Yet, regardless of their realistic fears and concerns, some people did come forward to report crimes of sexual assault and childhood sexual abuse. It takes a strong and motivating reason to report to the police despite their fears and the main reason given by participants concerned the need to protect others from the perpetrator.

## **MAJOR THEMES IDENTIFIED BY STUDY PARTICIPANTS**

Table 3 shows the main themes that were discussed by the participants in each respondent group to provide an overview of the categories or themes described in the results). The shaded themes in Table 3 indicate the major themes that emerged from the data analysis. The results from Table 3 have been used to synthesize the main findings and develop a concept map that summarizes the predominant themes of the study. The concept map provides a guide for developing strategies for change, as described below.

The analysis for developing the concept map focuses on themes that were raised most frequently by the project participants. However, in focusing on the dominant themes, we must not lose sight of some important themes that were mentioned by a minority of the respondents in this study. One such theme, mentioned by less than a third of service participants, dealt with the fear that prevents individuals from reporting assaults. This is clearly a critical issue that must be addressed so progress can be made in holding the perpetrators of sexual assaults and sexual abuse accountable for their crimes through the criminal justice system. The minor themes that emerged from the analysis must not be overlooked since a number of them deal with areas that must be changed if there is to be progress in meeting key needs. In addition, some themes arose in response to specific questions posed to the participants while others were mentioned because they were particularly salient to individual participants (e.g. sexual misconduct, advocacy, and community safety concerns). Had questions been posed consistently in every interview to probe into these issues, it is likely that they would have figured more prominently in the results.

Nevertheless, the data analysis shows that certain issues arose repeatedly in the focus groups and interviews. Recurring themes or categories raised by a majority of the participants indicate particular areas of focus for the development of programmes to address the needs of the study group. Categories were deemed to be major themes when 60 percent or more of the participants in either respondent group discussed the topic. It should be noted that the major theme *Further Services* combines many respondent suggestions for programmes. Individually, each of the programming suggestions was discussed by less than 60 percent of the respondents (i.e. cut-off we have used to identify the major themes). Therefore, these suggestions have been grouped together.

The major themes have been incorporated into a concept map (see Figure 1). This study examined the gaps in services for people with a mental illness who also had underlying issues of sexual abuse/assault and the mental health continuum of this population is depicted as the starting point on the concept map. The concept map is action oriented and the goals seek to improve existing services, reduce barriers to services and to bridge the gap in services.

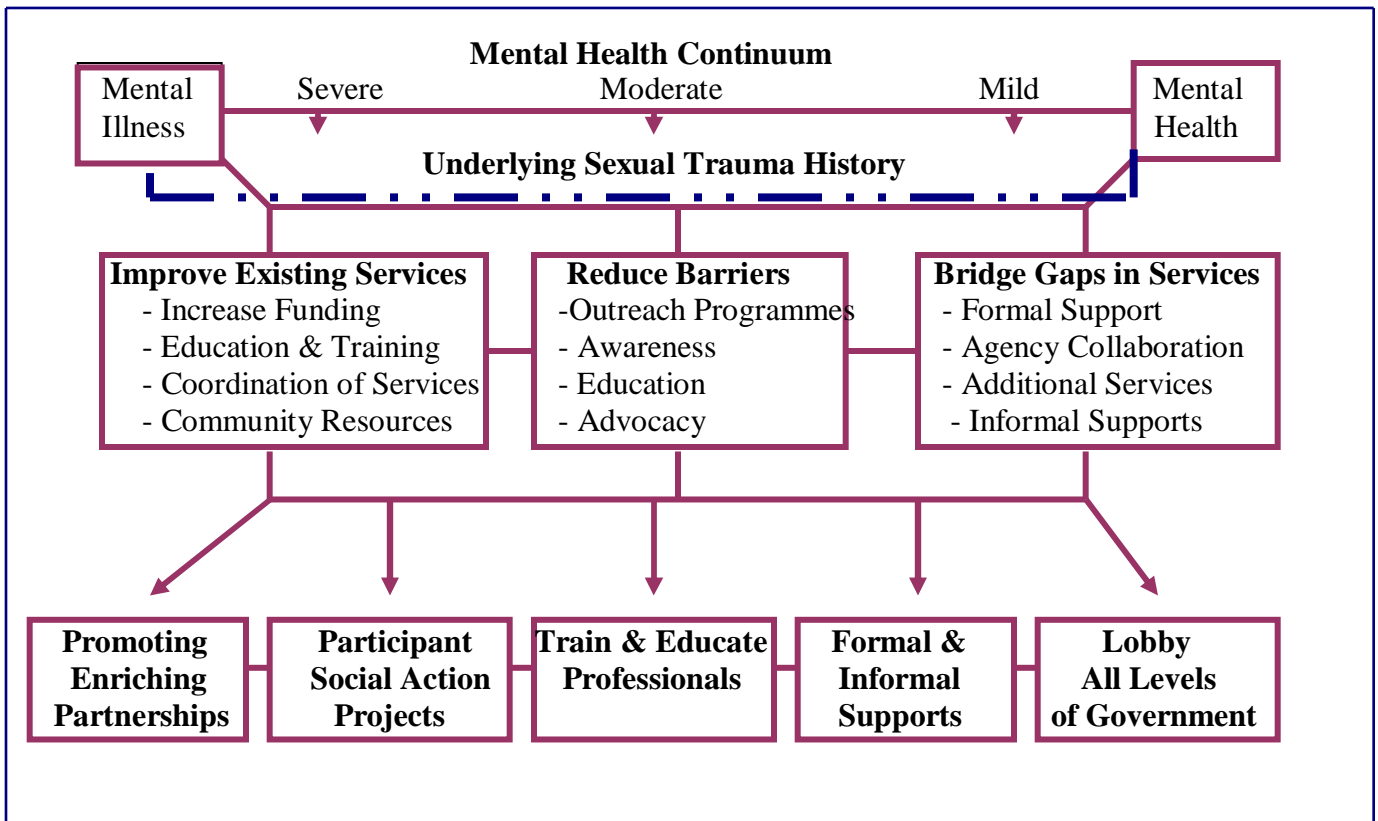
It is important to recognize that any vision of change must be based on existing strengths in order to increase the probability of achieving the objectives. The participants in this study identified numerous strengths in service organizations, staff and service participants. These strengths (discussed in detail in the report) have formed the

foundation of the proposed action plan that has been derived from the major themes identified by study participants.

**Table 3. Dominant Themes Emerging from the Data Analysis**

MAJOR THEMES	SERVICE PARTICIPANT <sup>a</sup>	SERVICE PROVIDER <sup>b</sup>
	Percentage of Responses (%)	
<b>STRENGTHS</b>		
Strengths of Service System	83	93
Strengths of Staff	73	65
Staff's Personal Qualities	83	13
Strengths & Abilities of Service Participants	88	15
<b>PROBLEMS</b>		
Problems with Service Delivery	53	93
Problems with Staff	75	70
<b>BARRIERS</b>		
Barriers in Existing Services	78	63
Barriers with Staff	78	43
Practical Barriers	43	41
Barriers – Client Abilities	73	90
Barriers – Stigma	73	93
Barrier- Community Concerns	25	19
Barrier – Little Family Support	73	90
<b>BARRIERS TO REPORTING</b>		
Barrier- Attitudes of Legal Professionals	60	43
Barrier – Fear	28	37
Barrier – Revictimization in Court	45	29
<b>GAPS IN SERVICES</b>		
Formal Support Systems	65	82
Informal Support Systems	76	63
Advocacy	28	36
Further Services	63	93
Therapeutic/Educational Groups	25	25
Residential – Treatment and Shelter	23	28
<b>DECREASE VULNERABILITY</b>		
Education and Awareness	45	32
<b>ASSIST DISCLOSURES</b>		
Education and Awareness	45	35
<sup>a</sup> Percentage of service participant sample that identified and discussed this theme.		
<sup>b</sup> Percentage of service provider sample that identified and discussed this theme		

**Figure 1. Concept Map: Framework For Community Capacity Building**



***Strengths to Utilize and Build On***

The existing organizations, services, programmes, service provider staff and service participants of this community have identified many strengths that have been discussed in this report. The strengths can become the foundation for continued enhancement of the services available in the communities in Lambton County.

Service providers (93%) discussed many existing strengths in the present system of service delivery. Staff members (65%) recognized their own expertise in the knowledge, training and experiences that were related to their own service organizations.

In Figure 1, the community capacity building model, the existing strengths of service organizations and service staff members are recognized and utilized under the category **Promoting Enriching Relationships**. It is possible that this rich pool of knowledge could be used to address the training needs for staff identified by service providers (70%) and service participants (75%). This knowledge base can also help to address the need for increased collaboration to improve service delivery that service providers (93%) noted and reduce barriers for service participants accessing services (73% service participants and 90% service providers).

Collaborative service relationships could be fostered through the following strategies:

- In-service cross-training opportunities to share areas of expertise, build awareness of community programmes and resources and personalize relationships between organizations;
- Foster improved coordination of services by formal front-line staff networking opportunities and relationship building between workers;
- Mentoring programmes where identified staff members are open to sharing their expertise and resources with less experienced staff in other organizations; and
- Outreach programmes to provide service within different organizations and cultural communities.

Service participants (83%) readily identified many exceptional qualities of the present service provision. The strengths of staff members (73%) as well as the personal qualities of many service providers (83%) were identified by service participants as key factors in successful service provision. Service participants (88%) also identified their own gifts, abilities, talents and experiences as important and felt they were underutilized within the community.

In Figure 1, the strengths of service participants are employed and developed under the category of **Participant Social Action Projects**. This category could 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). All participant social action projects would be identified and chosen by participants and they would be based on the strengths of the group members. Possible social action projects could involve the following activities:

- Roles of peer advocacy;
- Public education and awareness campaigns to address stigma and increase public awareness of community services;
- Facilitating informal support systems;
- Compiling and maintaining community resource guides in hard copy and on a web site; and
- Lobbying the government for more funding for social services through petitions, letters, on-line mass emails to ministers of parliament and projects that further the goals of service participants in an empowering process.

The need for continued training and education for professionals from all disciplines that provide service to the study population was recognized by service participants and service providers as the best method for addressing stigma the major themes of problems with staff (75% service participants and 70% service providers), barriers with staff (78% service participants) and attitudes of legal professionals (60% service participants).

Under the category of **Train and Educate Professionals**, in Figure 1, the focus of the training and education could address the multiple issues that this population faces and

provide all service providers with an understanding of mental illness, sexual abuse/assault and addiction issues as well as techniques to assist participants (75% service participants and 70% service providers). As well as increasing the knowledge and sensitivity of service providers to these matters, the provision of training would also assist them to advocate for service participants as they became aware of how these experiences impact on service participants' abilities to access (73% service participants and 90% service providers) and follow through with services. Formal training opportunities could be offered as in the following ways:

- Workshops on specific issues identified by service providers;
- Lectures by noted specialists in the mental health and sexual abuse/assault fields;
- Training by experts on selected issues that would provide techniques and tools for assisting service participants;
- Sensitivity training; and
- Ongoing consultation opportunities.

A lack of family support was identified as a major theme in the category dealing with barriers (73% service participants and 90% service providers). As discussed in the results of this report, the lack of formal and informal support systems in the community were recognized as being problematic for service participants and detrimental to their abilities to access services, reduce hospitalizations and maintain stability.

Developing formal supports connected to service organizations (65% service participants and 82% service providers) and informal support systems based on peer support (76% service participants and 63% service providers) was considered important. In figure 1, the category **Formal and Informal Supports** promotes the development of both ongoing forms of support as an action that could have long-term benefits for the community. Formal supports could take many forms, including the following:

- Closed educational groups connected to a particular service addressing discrete topics;
- Open groups that provide discussion of a broad range of topics and offer support;
- Drop-in social groups;
- Groups developed around a particular modality (e.g. journal writing, art therapy, book discussions);
- Recreational groups (e.g. baseball, bowling, cards); and
- Peer mentoring.

Informal supports could be fostered by:

- Peer network building;
- Identifying natural supports in the community; and
- Identifying free community social opportunities.

As was noted above, the service system in Lambton County has many strengths. The current gaps in services, barriers to accessing services and problems in the existing services are primarily due to the downloading of services to local communities, funding

cut backs or lack of funding increases to meet the increased demands. In Figure 1, the last category, **Lobby All Levels of Government**, is a call to action for service providers and service participants. It will require a concentrated community effort in lobbying all levels of government to address the chronic shortage of funding that has had such a detrimental and divisive affect on service provision. Community capacity building is not just the result of creating a collaborative vision but it demands adequate funding to make this vision a reality.

### **THE NEXT PHASE – YEAR TWO AND YEAR THREE OF THE STUDY**

This report and participants' recommendations will be presented in a public forum. The next two years of the study will be dedicated to the development and evaluation of any programmes, resources, trainings or processes that are the result of this study. At the conclusion of the second year (July, 2006) an interim report on the study's progress will be available and, at the completion of the entire study at the end of the third year (July, 2007), a formal report will be presented regarding the results of the programme evaluations.

### **REFERENCES**

- Arvidsson, H. (2003). Met and unmet need of severely mentally ill persons: the psychiatric care reform in Sweden. *Soc Psychiatry Psychiatr Epidemiol*, 38, 373-379. [On line] Academic Search Premier
- Baigent, L., Shaw, R. & Chalmers, F. (2004). *Health system monitoring report*. Essex, Kent and Lambton District Health Council.
- Banyard, V.L., Williams, L.M. & Siegel, J.A. (2001). The long-term mental health consequences of child sexual abuse: an exploratory study of the impact of multiple traumas in a sample of women. *Journal of Traumatic Stress*, 14(4), 697-715. [On line] Academic Search Premier.
- Bassett, H., Lampe, J. & Lloyd, C. (1999). Parenting: Experiences and feelings of parents with a mental illness. *Journal of Mental Health*, 8(6), 597-604. [On line] Academic Search Premier.
- 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.
- Berg, S., Carr, H., Hunter, H. & Wai, N. (2004). *Evaluating services in lambton county from the perspective of abused women*. Sarnia-Lambton Coordinating Committee on Violence Against Women. Unpublished.
- Bohn, D.K. (2003). Lifetime physical and sexual abuse, substance abuse, depression and suicide attempts among native American women. *Issues in Mental Health Nursing*, 24, 333-352. [On line] Academic Search Premier.

- Brown, A.H., Grella, C.E., & Cooper, L. (2002). Living it or learning it: Attitudes and beliefs about experience and expertise in treatment for the dually diagnosed. *Contemporary Drug Problems, 29*, 687-710. [On line] Academic Search Premier.
- Canadian Mental Health Association. (2003). *Access to mental health services: issues, barriers and recommendations for federal action*. A brief to the Standing Committee on Social Affairs, Science and Technology.
- Canadian Resource Centre. (1998). *Balancing the scales: the state of victims' rights in Canada*. [On Line] Academic Search Elite. Canadian Resource Centre [Producer and Distributor].
- Chandra, P.S., Deepthivarma, S., Carey, M., Carey, K., Shalinianant, M.P. (2003). A cry from the darkness: women with severe mental illness in india reveal their experiences with sexual coercion. *Psychiatry, 66*(4), 323-334/
- Cheasty, M., Clare, A.W. & Collins, C. (2002). Child sexual abuse—a predictor of persistent depression in adult rape and sexual assault victims. *Journal of Mental Health, 11*(1), 79-84. [On line] Academic Search Premier.
- Corrigan, P.W. (2002). Empowerment and serious mental illness: treatment partnerships and community opportunities. *Psychiatric Quarterly, 73*(3), 217-228. [On line] Academic Search Premier.
- Craig, T., Doherty, I., Jamieson-Craig, R., Boodock, A. & Attafua, G. (2004). The consumer-employee as a member of a mental health assertive outreach team: clinical and social outcomes. *Journal of Mental Health, 13*(1), 59-69. [On line] Academic Search Premier.
- Creedy, D., Nizette, D. & Henderson, K. (1998). A framework for practice with women survivors of childhood sexual abuse. *Australian and New Zealand Journal of Mental Health Nursing, 7*, 67-73. [On line] Academic Search Premier.
- Dewa, C, Rogers, J., Kates, N. & Goering, P. (2000). *Community Care for Individuals Moderately Affected by Mental Health Problems (MMI): Best Practices*. Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.
- Elhai, J. D., Klotz Flitter, J.M., Gold, S.N. & Sellers, A.H. (2001). Identifying subtypes of women survivors of childhood sexual abuse: and mmpi-2 cluster analysis. *Journal of Traumatic Stress, 14*(1), 157-175. [On line] Academic Search Premier.
- Elhai, J.D., Gold, S.N., Mateus, L.F. & Astaphan, T.A. (2001). Scale 8 elevations on the mmpi-2 among women survivors of childhood sexual abuse: evaluating

- posttraumatic stress, depression and dissociation as predictors. *Journal of Family Violence, 16(1)*, 47-57. [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.
- Fox, M., Greaves, C. & Perry, J. (2003). The use of interface workers to facilitate child and adolescent mental health services in primary care: a qualitative assessment. *Primary Health Care Research and Development, 4*, 169-176.
- Ganzevoort, R.R. (2002). Common themes and structures in male victims' stories of religion and sexual abuse. *Mental Health, Religion & Culture, 5(3)*, 313-325. [On line] Academic Search Premier.
- Goodman, L.A., Salyers, M.P., Mueser, K.T., Rosnberg, S.D., Swartz, M., Essock, S.M., Osher, F.C, Butterfield, M. I. & Swanson, J. (2001). Recent victimization in women and men with severe mental illness: prevalence and correlates. *Journal of Traumatic Stress, 14(4)*, 615-632. [On line] Academic Search Premier.
- Goodman, L.A., Dutton, M.A. & Harris, M. (1997). The relationship between violence dimensions and symptom severity among homeless, mentally ill women. *Journal of Traumatic Stress, 10(1)*, 51-70. [On line] Academic Search Premier.
- Gutierrez, P.M., Thakkar, R.R. & Kuczen, C. (2000). Exploration of the relationship between physical and/or sexual abuse, attitudes about life and death, and suicidal ideation of young women. *Death Studies, 24*, 675-688. [On line] Academic Search Premier.
- Hankin, C.S., Skinner, K.M., Sullivan, L.M., Miller, D.R., Frayne, S. & Tripp, T.J. (1999). Prevalence of depressive and alcohol abuse symptoms among women and outpatients who report experiencing sexual assault while in the military. *Journal of Traumatic Stress, 12(4)*, 601-612. [On line] Academic Search Premier.
- Health Canada (1997). *Risk, vulnerability, resiliency – health system implications. Background paper for Roundtable Discussion*. Public Health Agency of Canada. Publications Health Canada.
- 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.

- Human Resources Development Canada. (2001). *A collection of statistical data for Lambton county an its census subdivisions.*
- Keilty, J. & Connelly, G. (2001). Making a statement: an exploratory study of barriers facing women with an intellectual disability when making a statement about sexual assault to police. *Disability & Society, 16(5), 273-291.* [On line] Academic Search Premier.
- Kelly, K.R. (1996). Review of clinical mental health counselling process and outcome research. *Journal of Mental Health Counselling, 18(4).* [On line] Academic Search Premier.
- King, J.A., Mandansky, D., King, S., Fletcher, K. & Brewer, J. (2001). Early sexual abuse and low cortisol. *Psychiatry and Clinical Neurosciences, 55, 71-74.* [On line] Academic Search Premier.
- Laberg, S. Tornkvist, A & Andersson, G. (2001). Experiences of patients in cognitive behavioural group therapy: a qualitative study of eating disorders. *Scandinavian Journal of Behaviour Therapy, 30(4), 161-178.* [On Line] Academic Search Premier.
- Lefebvre, J., Cyr, M., Lesage, A., Fournier, L. & Toupin, J. (2000). Unmet needs in the community: can existing services meet them? *Acta Psychiatrica Scandinavica, 102, 65-70.* [On line] Academic Search Premier.
- Levitan, R.D., Rector, N.A., Sheldon, T. & Goering P. (2003). Childhood adversities associated with major depression and/or anxiety disorders in a community sample of Ontario: issues of co-morbidity and specificity. *Depression and Anxiety, 17, 34-42.* [On line] Academic Search Premier.
- Macpherson, R., Haynes, R., Summerfield, L., Foy, C. & Slade, M. (2003). From research to practice: a local mental health services needs assessment. *Soc Psychiatry Psychiatr Epidemiol, 38, 276-281.* [On line] Academic Search Premier.
- Maker, A.H., Kemmelmeier, M. & Peterson, C. (2001). Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: a multi-risk model of revictimization. *Journal of Traumatic Stress, 14(2), 351-368.* [On line] Academic Search Premier.
- McCrone, P., Leese, M., Thornicroft, G., Schene, A, Knudsen, H.C., Vazquez-Barquero, J.L., Tansella, M., Becker, T. & Chisholm, D. (2001). A comparison of needs of patients with schizophrenia in five European countries: the epsilon study. *Acta Psychiatrica Scandinavica, 103, 370-379.* [On line] Academic Search Premier.

- McIntyre, S. (2001). *Where are we now: reckoning with resistance to feminist efforts to reform sexual assault laws*. Paper presented at the meeting of Canadian Association of Elizabeth Fry Societies and Canadian Association of Sexual Assault Centres, Ottawa, Ont.
- McKinlay, D. (2001) *Sexual assault survivors' experiences within the court process—results of a Sarnia qualitative study*. Research study presented at the meeting of Canadian Association of Elizabeth Fry Societies and Canadian Association of Sexual Assault Centres, Ottawa, Ont.
- Mclean, L.M. *Childhood sexual abuse and adult psychiatric diagnosis: current views and clinical implications*. Toronto: University of Toronto.
- Naar-King, S., Silvern, L., Ryan, V. & Sebring D. (2002). Type and severity of abuse as predictors of psychiatric symptoms in adolescence. *Journal of Family Violence*, 17(2), 133-149. [On line] Academic Search Premier.
- Nelson-Gardell, D. (2001). The voices of victims: Surviving child sexual abuse. *Child and Adolescent Social Work Journal*, 18 (6), 401-416. [On line] Academic Search Premier.
- New, M. & Berliner, L. (2000). Mental health service utilization by victims of crime. *Journal of Traumatic Stress*, 13(4), 693-707. [On line] Academic Search Premier.
- 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.
- Nurcombe, B. (2000). Child sexual abuse 1: psychopathology. *Australian and New Zealand Journal of Psychiatry*, 34, 85-91. [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.
- Palmer, R.L. & Oppenheimer, R. (1992). Childhood sexual experiences with adults: a comparison of women with eating disorders and those with other diagnoses. *International Journal of Eating Disorders*, 13(4), 359-364. [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.

- Ramana, R., Paykel, E.S., Melzer, D., Mehta, M.A. & Surtees, P.G. (2003). Aftercare of depressed inpatients: service delivery and unmet needs. *Soc Psychiatry Psychiatr Epidemiol*, 38, 109-115. [On line] Academic Search Premier.
- Read, J., Agar, K., Argyle, N. & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions, and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 1-22. [On line] Academic Search Premier.
- Salize, H.J., Horst, A., Dillmann-Lange, C., Stern, G., Wolf, I., Henn, F., Rossler, W. (2001). Needs for mental health care and service provision in single homeless people. *Soc Psychiatry Psychiatr Epidemiol*, 36, 207-216. [On line] Academic Search Premier.
- Schmidt, U., Humfress, H. & Treasure, J. (1997). The role of general family environment and sexual and physical abuse in the origins of eating disorders. *European Eating Disorders Review*, 5(3), 184-207. [On line] Academic Search Premier.
- Slavik, S., Carlson, J. & Sperry, L. (1995). Extreme life-styles of adults who have experienced sexual abuse. *Individual Psychology*, 51(4). [On line] Academic Search Premier.
- Statistics Canada (2001). Community Profile: Lambton County. [On Line]. <http://www12.statcan.ca/english/profil01/Details/>
- Ullman, S.E. & Brecklin L. R. (2002). Sexual assault history, ptsd, and mental health service seeking in a national sample of women. *Journal of Community Psychology*, 30(3), 261-279. [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.
- Vajda, J. & Steinbeck, K. (2000). Factors associated with repeat suicide attempts among adolescents. *Australian and New Zealand Journal of Psychiatry*, 34, 437-445. [On line] Academic Search Premier.
- Wood, P., Pill, R., Prior, L. & Lewis, G. (2002). Patients' opinions of the use of psychiatric case-finding questionnaires in general practice. *Health Expectations*, 5, 282-288. [On line] Academic Search Premier.
- Wilson, C.J., & Deane, F.P. (2001). Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. *Journal of Educational and Psychological Consultation*, 12(4), 345-364. [On line] Academic Search Premier.

- Young, E.A., Abelson, J.L., Curtis, G.C. & Nesse, R.M. (1997). Childhood adversity and vulnerability to mood and anxiety disorders. *Depression and Anxiety*, 5, 66-72. [On line] Academic Search Premier.
- 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.
- Zoellner, L.A., Goodwin, M.L. & Foa, E.B. (2000). PTSD severity and health perceptions in female victims of sexual assault. *Journal of Traumatic Stress*, 13(4), 635-649. [On line] Academic Search Premier