Partner Abuse, Volume 10, Number 4, 2019

All Women Are Welcome: Reducing Barriers to Women's Shelters With Harm Reduction

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Women who experience domestic violence are more likely to use or become dependent on substances. Their health and safety are at greater risk when Violence Against Women (VAW) shelters have policies prohibiting admission if noticeably impaired. Harm reduction strategies can help reduce harms caused by substance use. Minimal research was found about impacts of integrating harm reduction in VAW shelters. We examined women's experiences with a harm reduction service delivery model at a Canadian rural VAW shelter. Interviews were conducted with 25 former residents to explore their experiences. Most women preferred to have harm reduction implemented, although most women also wanted changes made to harm reduction practices. These recommended changes would enhance positive experiences and feelings of safety for all women, thereby achieving the goal of *all* women welcome. Overall, our findings support the integration of harm reduction in VAW shelters that balances harm reduction philosophy and practices with the individualized needs of traumatized women and safety of children.

KEYWORDS: domestic violence shelters; violence against women; substance use; trauma; safety

Many Violence Against Women (VAW) shelters have struggled to respond to the needs of women who seek their support and use substances. Often women are excluded from shelters when noticeably impaired (Baker, Billhardt, Warren, Rollins, & Glass, 2010; BC Society of Transition Houses, 2011; Martin, Moracco, Chang, Council, & Dulli, 2008; Schumacher & Holt, 2012). Shelter abstinence policies may impact the openness to discuss current substance use by women seeking shelter from violence (Baker et al., 2010; BC Society of Transition Houses, 2011; Schumacher & Holt, 2012). These exclusionary practices can place abused women at further risk of violence and other harms. The Ontario Ministry of Community and Social Services (MCSS, 2015) standards for emergency VAW shelters "expects that shelters provide access to all

http://dx.doi.org/10.1891/1946-6560.10.4.409

women seeking shelter services, including women who use substances" (p. 14). One method of implementing the standard is to use a harm reduction approach. This can eliminate exclusionary practices, but minimal information is available regarding the experiences of women accessing VAW shelters that use harm reduction approaches. The following study examines the experience of women who accessed a VAW shelter that uses a harm reduction approach.

LITERATURE REVIEW

Women who experience domestic violence are more likely to use or become dependent on substances (Baker et al., 2010; Fowler, 2007; Macy & Goodbourn, 2012; Martin et al., 2008; Peters, Khondkaryan, & Sullivan, 2012; Poole, Greaves, Jategaonkar, McCullough, & Chabot, 2008; Schumacher, & Holt, 2012; Tutty, Ogden, Giurgiu, & Weaver-Dunlop, 2014). Further, they are five times more likely than other women to become dependent on substances (Macy & Goodbourn, 2012). However, the extent of substance use by women who experience domestic violence is potentially underestimated (Fowler, 2007) or unknown (Schumacher & Holt, 2012), as shelter staff commonly do not acknowledge, discuss, or document substance use.

Women struggling with intimate partner violence (IPV) may use substances for many reasons. The initiation of first use may occur at any point. Many participants in Macy, Renz, and Pelino's (2013) qualitative study reported using substances before the violent relationship began. In other situations, the abusive partner introduces the woman to substances and pressures her to use with him (BC Society of Transition Houses, 2011; Macy et al., 2013). Using to cope with IPV-related stressors such as money and health issues is a common reason (Poole et al., 2008; Tutty et al., 2014), as well as a means to self-medicate to manage emotional and physical pain inflicted by abusive partners (BC Society of Transition Houses, 2011; Collins et al., 2012; Fowler, 2007; Peters et al., 2012; Schumacher & Holt, 2012). Women using for these reasons were associated with higher risk of problematic use (Peters et al., 2012). Regardless of the reasons for substance use, barriers to support or access to services, particularly for substance-using women also parenting children, were evident (Macy & Goodbourn, 2012; Martin et al., 2008; Pinkham & Malinowska-Sempruch, 2008; Schumacher & Holt, 2012). Denial of admission to shelters when noticeably impaired creates risk for revictimization and violence (BC Society of Transition Houses, 2011; Fowler, 2007; Martin et al., 2008).

The harm reduction approach was developed in non-residential healthcare settings. It is both a philosophy and practice which prioritizes reducing negative consequences of substance-using behavior and promotes safer consumption (Lee, Engstrom, & Petersen, 2011; Lee & Zerai, 2010). The approaches are value-neutral about substance use. Use is acknowledged and not judged, thereby promoting respectful relationships and treating all people as worthy and with dignity (Pauly, 2008). Neither abstinence nor treatment for substance use are goals of harm reduction; however, harm reduction advocates recognize that some who use may have these goals (Lee et al., 2011). By using non-judgmental language and concrete strategies such as needle exchange programs, education, and provision of safer use kits, harms related to substance use are shown to be reduced (Pinkham & Malinowska-Sempruch, 2008).

Some studies reported participants felt less marginalized, more engaged in programming, had an improved quality of life and social functioning, and made changes in their substance use patterns, and future plans and goals (Lee & Zerai, 2010; Poole et al., 2008).

Harm reduction approaches have been implemented and studied in residential settings such as: prisons (Carlin, 2005); hospitals (McNeil, Dilley, Guirguis-Younger, Hwang, & Small, 2014; Strike, Guta, de Prinse, Switzer, & Chan Carusone, 2014); and housing programs, particularly Housing First programs (Collins et al., 2012; Henwood, Padgett, & Tiderington, 2014; Pauly, Reist, Belle-Isle, & Schactman, 2013; Pauly, Wallace, & Barber, 2018; Young & Manion, 2017). Some of the positive changes associated with their implementation included increased level and perception of safety for residents (Carlin, 2005, Strike et al., 2014); reduced stress or anxiety for staff (Carlin, 2005; Henwood et al., 2014); and the ability to maintain order or control more readily in the setting (Carlin, 2005; McNeil et al., 2014; Strike et al., 2014). Residents tended to discuss their substance use with staff more than in non-harm reduction settings (Henwood et al., 2014; McNeil et al., 2014; Strike et al., 2014); they tended to have more control over their lives (Carlin, 2005; Henwood et al., 2014); and denial of healthcare services decreased (Carlin, 2005; McNeil et al., 2014; Young & Manion, 2017). Stigmatization about substance use also decreased (McNeil et al., 2014; Strike et al., 2014), although some who used continued to experience internalized personal stigma (Collins et al., 2012). The issue of conflicts between those using substances and others when using substances was raised (McNeil et al., 2014; Pauly et al., 2018; Strike et al., 2014; Young & Manion, 2017), and indicated that residents who use substances and staff generally benefited from harm reduction approaches in residential settings, although the perspectives of non-using residents were not examined in most studies.

Few studies of the extent to which VAW shelters have implemented harm reduction were found. An informal survey conducted by the Ontario Association of Interval and Transition Housing (OAITH, 2013) reported that 35 of 45 participating shelters practiced minimal to comprehensive harm reduction approaches. Services described were often limited to strategies such as referring women to external treatment, but providing safe space for use of legal substances or working with an actively using woman were not commonly implemented. Consistent with the literature (Macy & Goodbourn, 2012; Martin et al., 2008; Schumacher & Holt, 2012), barriers to implementation included concerns with women's behavior (e.g., not following rules, aggression, bringing substances into shelter), resident and staff safety, staffing issues (e.g., lack of training, single-staffed), and needs of non-using women (OAITH, 2013).

Morton, Hohman, and Middleton (2015) described an Irish shelter that integrated harm reduction in its service delivery model, including the challenges and barriers to implementation. The overall goal was to "develop truly collaborative relationships with women" (p. 346). Many shelter staff believed abstinence was the best way to address substance use issues. Training regarding the effects, risks, and safe use of substances was seen as key to shifting staff's comfort level with discussions with women about ways to minimize the harms of substance use. Harm reduction

approaches implemented included: allowing women to store medications in their shelter apartments; an intake process which included assessment of substance use and support needs; development of a mutually beneficial relationship with the local drug and alcohol agency to provide on-site outreach and shelter staff training; and development of a partnership with child protection services to support substance using women with supervised access visits on site.

Minimal resources are available that provide guidelines about effective harm reduction practices for VAW shelters. The BC Society of Transition Houses (2011) created a toolkit to help reduce barriers faced by women fleeing from violence. This comprehensive document presents philosophical and "promising" practices regarding mental wellness and substance use and offers guidance with policy and procedure development to integrate harm reduction in the residential setting.

Although VAW shelters provide unique environments for implementation of harm reduction approaches, no studies were identified that examined the perspectives of all residents accessing a VAW shelter where harm reduction approaches have been implemented. Safety issues for other residents at the shelter were commonly cited as the rationale for not implementing harm reduction (Martin et al., 2008; Schumacher & Holt, 2012). Developing a greater understanding of harm reduction in VAW shelters from the perspective of women who use these services is important. This exploratory study qualitatively examined the question: How do women who have accessed this VAW shelter experience its harm reduction approaches?

METHOD

Sampling Strategy

Our sample of 25 participants was drawn from all previous residents who accessed the VAW shelter studied after its implementation of harm reduction approaches. A shelter employee contacted these women, beginning with those most recently discharged and worked back, until we had 25. The employee was provided with a script to ensure each woman initially contacted was clear that she was under no obligation to participate, was provided with study information, and sought verbal permission for researchers to contact her with an invitation to participate in a 1- to 2-hour interview. To facilitate participation, round trip transportation, on-site childcare, and refreshments were provided. The in-person interviews were conducted in private counselling areas at the shelter. Capacity to provide informed consent of all research participants was assessed by ensuring: (a) they understood the study purpose, their role, and that their participation is a voluntary choice; and (b) appreciated the impact their participation in the study may have on their own situation (i.e., benefits and risks of participating). Being under the influence of substances may or may not impede the ability to consent. If any participant demonstrated questionable capacity to provide consent due to substance use, the interview would not proceed and the woman would be connected to appropriate supports within the shelter to ensure her personal safety. No participants were excluded; those who arrived under the influence of substances were capable of providing informed consent. Each participant

was given a monetary honorarium. Shelter staff provided debriefing and support for participants who requested this.

Data Collection and Analysis Procedures

Use of semistructured interview questions ensured consistency and permitted flexibility to explore other information raised by participants. Questions were developed based on the research purpose, shelter guidelines, and harm reduction philosophy (see Appendix for specific questions). Interviews were audio–recorded and transcribed. NVivo was used to conduct a thematic analysis (Braun & Clarke, 2006, 2012; Nowell, Norris, White, & Moules, 2017). Broad coding categories were generated to create a coding manual. Two research assistants then coded the data, ensuring rigorous application of the manual codes for the first level of coding. The co-investigators reviewed the coding to ensure inter-coder reliability and then analyzed the coded data for themes. Next, we reduced and refined the data and coding to generate an initial draft of a thematic map that defined and named themes as outlined in phases' three to five by Braun and Clarke (2006). All participants were invited to review their transcripts to verify the information and for a presentation of the draft thematic map. Five participants attended. No content changes were made to transcripts. The thematic map was also presented to two shelter management staff. Feedback was integrated as appropriate. Articulated themes were further refined to capture intended messages and meanings. These findings were again shared with shelter management to allow for final input prior to external presentations.

The study was approved by our University Research Ethics Board in accordance with Canadian Tri-Council standards.

Setting Context and Harm Reduction Philosophy and Guidelines

The Canadian shelter studied provides emergency accommodation in a three-story building for up to 20 VAW and/or homeless women over the age of 16 and their children, including trans-women. The catchment area is mainly rural, inclusive of several small towns with no public transportation linking the communities. Approximately 80% of the women accessing shelter are of low economic status, with many relying on income security programs. Crisis support, individual counselling, and support groups for women and their children who have been exposed to violence are provided at the shelter. Information and referrals for other issues, such as substance misuse, are provided if requested by the woman.

The shelter integrates a harm reduction philosophy, meaning women are met with compassion, respect, and understanding in relation to substance use and other coping mechanisms, and operates using an intersectional feminist understanding of VAW. This is actualized within the residents' guidelines. The shelter allows residents to enter or remain if intoxicated, consumption of alcohol in residents' rooms only, medical marijuana use in a designated area on property, and storage of alcohol and other legal substances in a lock box in residents' rooms. No illegal substances can be consumed or stored on site.

Staff are expected to ensure their language and how they address issues and support women aligns with the harm reduction philosophy of respect, acceptance of residents' substance use, and provision of non-judgmental care. They provide access to: safer injection kits, safer inhalation kits, sharps containers, information on drug use, and development of plans for safe use off-site. Staff must maintain confidentiality, including residents' use of substances, with the exception of the legislated "duty to report" when children may be in need of protection.

Residents are expected to follow guidelines that support cooperative living. Those with children on site must supervise them at all times except when they have meetings with staff and/or other appointments. Under these circumstances, a staff member may supervise the children. Residents are expected to address their complaints by speaking with progressively more senior staff members, beginning with the staff member involved with the situation. Finally, residents are made aware that not adhering to the guidelines may result in eviction.

FINDINGS

Sample Demographics

The 25 participants[1] stayed at the shelter sometime between March 2013 and April 2016 for reasons of VAW (19) and homelessness (6). The total number of stays was 47, with 16 women having one stay and 9 having two or more stays. The average length of stay was 42 days. They ranged in age from early 20s to early 70s with an average age of 41.5 years. Many women (17) had children under the age of 18, while 8 women had adult children or no children. Of those with children under the age of 18, 10 had one or more of them staying at the shelter during the study period, totaling 19 children from infancy to under 17 years.

Sixteen women indicated they used licit and/or illicit substances while at the shelter. Licit use included using alcohol and medically prescribed substances including marijuana. Illicit use involved using illegal substances including medication not prescribed to the person and non-medicinal marijuana.[2] Of the 16 women, 6 indicated medical (i.e., prescribed marijuana and/or narcotics) or social use (i.e., occasional drinking), and 10 identified other use (i.e., using licit and/or illicit substances more substantially than social use). Women were not counted as "using" if they said they did not consume substances during their stay. The remaining nine women identified no substance use or long-term abstinence (i.e., more than 20 years) while at the shelter, including a few who identified they had never used.

Themes

Interview data were grouped into three broad interconnected themes: *experience, perceived safety*, and *ideal shelter*. We found that women's described experiences of harm reduction at the shelter impacted their perceptions of their physical and emotional safety and vice versa. Both the experiences and perceptions of safety influenced women's ideas about implementing harm reduction in their notions of the ideal shelter.

To illustrate these linkages, we present two cases representing opposing extremes of positive and negative experiences. Case 1: Lori[3] reported a very safe, positive shelter experience for both her and her son, and felt encouraged by staff's harm reduction practices. Although she did not tell staff about her substance use for fear of being reported to child welfare, she went to them for safer injection kits. These were provided without question or judgment. Other residents supervised her school-aged son when she needed to go out to use morphine. Lori was very positive about incorporating harm reduction. Case 2: Julia reported very problematic, negative experiences. Other residents' substance use triggered traumatic childhood experiences and caused her to feel unsafe. She felt unsupported when she reported concerns to staff and continuously contemplated returning home to further physical beatings as a better option. Julia supported having harm reduction in her ideal shelter but insisted on changes to ways staff interact with residents and intervene in situations. She was particularly concerned about limiting exposure of children to residents' substance using behavior.

Experience

Many women commented about the *shelter atmosphere* using harm reduction-related terms, such as non-judgment, access to services, and tolerance, respect, and understanding about substance use. Important elements of non-judgment to include in a harm reduction approach are to ensure staff present a neutral stance to use, particularly not judging people who use (Lee et al., 2011; Vakharia & Little, 2017). Our findings were consistent with this, as illustrated by Nancy who stated, "no matter what you have done . . . where you come from, no matter what you are doing, you're treated as a, a person here . . . there's no judgment here. [. . .] I have found a lot of other places I have gone for help and whatnot they judge you . . . judging because I smoked a little bit of marijuana." The neutral stance presented by some staff, however, was perceived by some participants as staff being unable to appropriately address concerns about substance use behavior because of non-judgment. Sandy indicated, "I guess [staff] can't really do much because they can't judge and I guess if they were to ask like you know, do you have a drinking problem I think you do, you are taking your kid until 3:00 in the morning then that would kind of be judgmental."

In other situations, staff appeared to take a not-so-neutral position by expecting residents to tolerate use among women. Sandy described this as positive, "[staff]'ve been pretty good at telling people to just you know, lay off so and so, and leave so and so"; whereas Deb experienced it as negative, "she was shooting up . . . the other mother and I wouldn't let her girls go upstairs and, and we both got pulled into the office and [staff] said 'hey look we have all kinds that come in here, you pretty much have to deal with it' . . . we have been abused, we have seen a lot, we have been through a lot, our children have already been through enough, I don't want to be told that I have to deal with it."

Harm reduction literature advocates reducing barriers to service access and defining substance use as a means of coping to facilitate understanding (Lee et al., 2011; Vakharia & Little, 2017). All participants were clear that women could access shelter services regardless of their level of intoxication. As Beth described, "when I came

here this time around I had been drinking . . . [crisis counsellor] greeted me again and I said thank you for everything- this is what happened, and she said okay, well you know, up to bed for you and we will see you in the morning." Participants seemed to have a shared view of substance use as a means of coping. Anne reflected on her observations of another woman at the shelter who was using as a means of coping: "that person needed that assistance in order to cope for the day, the person is a coping individual, that person has an addiction, that person is a functioning addict, an addict but functioning holding down a job, going to their job every day, is without a home but is without a home only because of a relationship problem right now."

Participants talked about their *interaction with the shelter staff* including how agency guidelines were handled. Many found the staff supportive and available. Fran indicated, "[Staff] will do anything for you. . . . They will give you the time." Similarly, Meg explained, "I got lots of help, they are here 24/7 if you ever needed someone to talk to." Lori stated, "[staff] were very respectful, they don't make you, you know, feel like you are any different, they really encouraged you with the harm reduction." Some women experienced staff as less supportive and less available, consistent with Glenn and Goodman's (2015) findings about general VAW shelter rules. For example, Sue described, "the [office] door is shut, we're out there . . . and somebody will go in and complain about something . . . you go and sit there and talk to it and it's all glossed over." Interestingly, Sue also acknowledged some specific staff that were actively involved with residents, "like the one that does the cooking [with residents], she is out there talking [with residents]," similar to Glenn and Goodman's recommendation that staff be more participatory.

Participants also experienced staff through their methods of handling concerns and their enforcement of guidelines, particularly about substance use and related behaviors. About half of the women, including those who did and did not use, appreciated the way staff addressed problems related to substance use. Tina appreciated staff handling of her concerns about another woman's drinking behavior: "[staff] called her in and told her . . . knock this off and stuff and you could have a drink in your room but you know, don't be bringing it anywhere else. So they told her off quietly, they didn't say it was me that complained because there were several other women going through and then they didn't put me in harm's way there." Other methods included redirecting behaviors, as Anne stated, "I've seen people come in [inebriated] that aren't quite, don't quite have all their wits about themselves and might need a hand upstairs to their bedroom and they get a hand upstairs," or, as a last resort, discharging a woman from the shelter.

Many participants focused on shelter rules. Linda described them as creating an atmosphere of mutual respect and problem-solving: "there are rules but there's very few rules . . . respect each other, you respect us, you respect this, this haven, this safe place and try to if you are using or abusing, or doing that and you want any help or you want to talk to us about it, we're always here." This was contrary to Glenn and Goodman's (2015) findings, in which participants experienced their shelter rules as punitive and were frustrated with the lack of flexibility. Beth described her positive experience with flexible guidelines, "you need to be in your room by a certain time

. . . but there is flexibility . . . so at 2:00 in the morning there was three of us that would sometimes be cleaning the bathrooms or doing laundry . . . it was again harm reduction, it wasn't us out on the street using, it was us in here and, and putting it to use." Ruth appreciated how staff handled her situation that caused some serious risk to herself and others after she ignored rules about not using certain substances in her room, "They talked to me about it and told me how like I know better . . . and I told them I did and, and I should have probably got the boot . . . I could have hurt a lot of people."

Not all thought staff handled issues well. Some, who used substances, found staff inappropriately addressed what they believed to be serious concerns regarding the use of substances other than alcohol on site. Julia provided this example: "they say that like at house meetings that you can't have [illicit drugs] here but at the same time I feel like they turn a blind eye to it because people do use, do use drugs in their rooms here." Pauly et al. (2018) identified "turning a blind eye" as a particularly concerning and risky behavior observed by Housing First residents and acknowledged by staff. Julia expanded her example by describing the impact of one situation, "we both were hiding ourselves and our daughters in our rooms upstairs for fear of the other women's behaviour on her drugs, yet nothing was done by staff . . . I know that the, some of the staff don't really like me here for voicing my concerns . . . I didn't get anywhere with them."

Most participants identified *concerns about child residents.* These centered on children's routines, similarities to homes they left, and what children may or may not have witnessed or learned while in the shelter. Concerns existed regardless of whether or not they had children or had children staying with them at the shelter and whether or not they used substances. A few women found other resident's substance use was disruptive to their children's routines. For example, Mil said "I know for a fact that users at 3:00 am are a problem to the parents who have to get up with the children who are being woken up and get them to school and expect them to have a good day." A few others found the experience was similar to home for their children, as they had been exposed to substance use there. Liz described: "a [resident] needed to use and she also needed to eat . . . and she was stumbling around and being loud and expressing herself in ways that you don't really want your children to see and it's around breakfast time because they are still up from the night previous . . ." However, Liz managed this situation by taking the children to their room, somewhat similar to their home routine, where she would tell the children to "just give dad a couple more minutes and we will go into the other room and, and do something else until dad is situated." Yet, a few other women indicated that their children did not witness anything related to substance use.

Overall, many women experienced the atmosphere, staff, and other residents at the shelter positively. Several women raised important concerns regarding experiences for children, adherence to guidelines, and how staff addressed the issues raised pertaining to others' use and related behavior. Participants tended to present their feedback in a balanced manner.

Perceived safety

Participants' *sense of safety* was an important component of perceived safety. Several women felt safe for a variety of reasons in relation to harm reduction being implemented. Joan said, "I did drink with people that were here and I liked that you had that option . . . because then you don't have to go out in the community and you can be safe here." Linda indicated, "I had a safety plan that if I am not back so I felt strong enough to leave . . . it would have been too scary and too awful to go to a place that would just be like these are the rules, this is what you are allowed to do. I would have probably just stayed in my room all day and not even come out."

Several other women, who did and did not use substances, felt unsafe in the shelter. Julia stated, "I am a user myself . . . I don't feel safe here at all, I feel more at risk for triggering my drugs here because of the other woman using." Additionally, Julia's perceived safety was exacerbated by triggers from her past trauma. She struggled seeing women using while caring for their young children: "I didn't know what to do, like do I stay here and I am not being abused anymore but I am triggered so badly by seeing these kids that are being abused {Cries} and nothing being done for them or do I go back and get beat up?" Julia expressed lack of support from staff around her triggering. Her experience was contrary to trauma-informed approaches that train staff to recognize her experience as triggering, teach strategies to deal with triggers, and work with her to clearly understand the rules and policies of the program (Covington, 2008; The Jean Tweed Centre, 2013).

About half of the women, including those who use, formerly used, and do not use, indicated they were triggered by others' substance use about their own past and/or present use and/or past trauma. Triggering affected their sense of safety and their need for more support and understanding from staff. It pertained not only to other residents' substance use but also some related behaviors. For example, Liz explained, "when you are coming from an abusive home life and people [at the shelter] are violent and throwing things and yelling, and screaming . . . it just takes me back to when I am arguing and fighting with my ex . . . you are smelling alcohol on somebody's breath when they are talking to you that takes you right back to the same thing." The women who discussed their triggers found this part of the interview emotionally difficult to express; in addition to their words, the intensity of their emotions contributed to a very powerful finding about the relationship between substance use at the shelter and past trauma.

Other residents' behavior also contributed to participants' sense of safety. Others' behaviors can be challenging in any residential setting. The circumstances that bring women together in a VAW shelter exacerbate some of these challenges and greatly impact a woman's perceived safety. About half of our participants identified careless use and bullying behaviors, specifically related to substance use, as problematic. More women who used substances than did not identified situations of careless use and bullying behaviors by others who use. Careless use was generally related to unsafe practices and not following the shelter's guidelines, particularly when intoxicated. Joy described, "she's got a needle in her hand no cap on it, and she's like walking around

the halls, I am like . . . get in your f—ing room, get rid of that, so she put it like up in the top of a, on the door but not even in her room or it was out in the hall on the top of the bathroom door . . . I had to go to tell a staff." Joy also provided an example of her own careless use when she was high that could have caused serious damage to the shelter.

Bullying experiences, both perceived and actual, were also identified. Rose, who did not use substances, shared, "I had a friend [at the shelter] . . . she likes morphine and she does it by needle. I caught her in the bathroom actually doing a, a hoot. I didn't tell staff because she's my friend and I am kind of threatened by her a little bit because she's a little tougher so I didn't say anything." In addition to feeling unsafe when other residents were not following rules, she also felt intimidated. Examples of direct bullying behavior involved women looking for substances, using verbal or physical intimidation, or becoming aggressive when using, as Kim described, "you have a girl that's in here and when she hits like 6 beers all she wants to do is fight, but you have also got another one coming in that just came out of an abusive relationship." The experience of other residents' aggressive behavior for women after just leaving an aggressor can be extremely difficult. Some of the bullying was also associated with "cliques" and peer pressure to use. However, there was a positive side to cliques for some women. Jan recalled, "I just remember being in my room and drinking. . . . And there was a couple of people in there with me . . . It's a social thing."

Safety concerns specific to children, particularly about children's exposure to substance use, others' behaviors when intoxicated (e.g., anger, yelling, overdose situations), and potential associated risks for the children were identified by many women, including those who did not use and about half of those who used substances while at the shelter. Deb stated, "our children have already been through enough I don't want to be told that I have to deal with it . . . as a mom that's been abused enough you don't want your children to have to see any more than they have to see." Contrarily, some others were not concerned about safety. Emma indicated, "[staff] would review the rules about [substance use] and how to do it in a proper way so that I didn't have to feel worried for my children."

Safety of children is one of the most commonly cited concerns about implementing harm reduction (BC Society of Transition Houses, 2011; Morton et al., 2015; OAITH, 2013). The concern is not unwarranted as problematic substance use is identified as a risk factor for child maltreatment, particularly pertaining to adequate supervision of children and their exposure to use, which often results in reports to child protection services (Simon & Brooks, 2017). Participants were very aware of the staff's and even a resident's duty to report to child protection officials when children may require protection. As Mil said: "if you're using, if you're out 5 out of 7 nights a week smoking crack and getting high, the staff should actually be calling, because your kids aren't making it to school, there's nobody with them in the mornings, you are sleeping until 3:00 in the afternoon." Contrary to Mil's opinion, some staff presented a different message about their duty to report regarding mothers' substance use. A few women described some situations of neglect and risk they observed, but when they reported this to staff, they were told to report the women themselves, as Julia experienced:

"when I came to staff and advised of the drug use with the, the mother using around her babies [. . .] I would have liked to have not been met with staff saying to me 'well, you call children's aid if you think it's something'."

A few other women did not disclose their use of substances to staff out of fear of being reported to child protection services. Macy et al. (2013) found that substance using mothers are often hesitant to seek support or shelter from domestic violence for fear of losing their children to protective services. Lori expressed similar hesitation, "nobody really knew that I was using . . . it wasn't something I really wanted to share with anybody and I had never been [at this shelter] before so I didn't know [if staff think] 'oh, if she's using and she has a kid I am going to call [child services]' . . . it's kind of scary, you don't know what to expect." Macy et al. recommend stronger attention to working with women to achieve safety, provide support with their substance use, and ensure the safety of their children while seeking this support. Had staff communicated this support more clearly, Lori may have been less fearful about disclosing to staff.

A few others were appreciative that staff did not report situations of use/intoxication with their children present. Some examples suggested they received support at these times and the safety of their children was ensured. Sandy shared, "I came in after drinking and I had my kids . . . [staff] didn't say anything to me, they just kind of laughed it off like my kids weren't in danger or anything like they were clearly, I was you know, like I had full control over myself but . . . [staff] keep just enough of an eye open and like you know, they are on guard . . . " Although the resident handbook outlined staff's duty to report, the meaning remained ambiguous for residents.

In summary, perceptions of safety were greatly impacted by a woman's past experiences with substances and/or violence in conjunction with her current experiences of other residents' behavior while using. Safety concerns were heightened for participants when children were exposed to residents' substance use and related behaviors, and if child protection issues were observed or perceived. To further complicate perceptions of safety, women expected stronger staff responsiveness and action to several of their identified concerns, particularly regarding protection of children.

Ideal shelter

To identify perspectives on whether or not harm reduction should be practiced in shelters, participants were asked to describe their ideal shelter, including whether or not harm reduction would be implemented. Although the experience and perceptions of safety appear to suggest that several women would be opposed to having harm reduction in their shelter, this was not the case. Only a few women, none of whom used substances, believed harm reduction should not be used, and primarily for safety reasons. Rose stated, "No, because it's supposed to be a safe place for women and their children to come, not for people to get drunk." Most women, regardless of use or non-use, stated that harm reduction would be used in their ideal shelters. Of these, several indicated it should be exactly like the shelter studied. For example, Joan identified, "this is an ideal shelter. I don't think I would change a thing." Emma stated "I do

believe that it is important to keep the supports that [this shelter] has and how the system is running in regards to women that do drugs and alcohol or medication, or pills."

While most women affirmed harm reduction, many of these women were very clear changes were needed to the way harm reduction practices were implemented in the shelter studied. Changes to physical environment and shelter guidelines were recommended. About half of the women suggested dividing the physical layout into wings for different reasons. Some suggested a separate wing for the women with children. For example, Anne stated "it would definitely have two different wings, it would have a wing for, for women with children and it would have a wing for women without children." Others suggested a separate wing for the women who use substances. Liz said, "if there was a separate section for users and it's not because I'd like to see segregation but if there was a separate, separate section when they are under the influence than it would make it easier to go through daily routines."

Guidelines regarding substance use were important to several participants in their ideal shelter. Some wanted more rules, while others suggested they would ensure stricter enforcement of guidelines. For example, Mil indicated, "you get caught drinking open liquor in the common area where the kids are you are out, done, there is no second or third chance, . . . you signed that paper saying you wouldn't bring your booze down here." Julia suggested stronger staff observance, "if there is going to be a shelter where harm reduction is going to be offered then there should definitely be some strict guidelines that staff must obey." Several referenced "improved monitoring" by suggesting that staff frequent areas in the shelter further away from the office, such as the bedroom areas on the upper levels. Overall, most women supported harm reduction within this shelter as they contemplated their ideal shelter, with many qualifying their support by suggesting some important changes pertaining to substance use practices.

DISCUSSION

The findings illustrated that implementing harm reduction in a women's shelter is complex. Service delivery in residential settings differs substantially from the health settings in which harm reduction was developed. In health settings, service delivery focuses on the person who uses substances. In residential settings such as an emergency women's shelter, other residents, who may or may not use substances, as well as children, are present, adding layers of complexity for the service provider and residents. We found issues of conflict between residents and recommendations for separate wings, similar to those identified by Strike et al. (2014) and McNeil et al. (2014). The shelter's goal with harm reduction was to ensure that *all* women are welcome, including those who use substances. The issues arising suggest that this has not yet been achieved. However, achievement may be possible, especially if the women's suggestions are heeded. Most women preferred to have harm reduction implemented, although most women also want changes made to harm reduction practices. These

recommended changes would enhance positive experiences and feelings of safety for all women, thereby achieving the goal that *all* women are welcome.

It may seem surprising that most participants supported harm reduction in shelters, given the negative experiences and concerns some women identified. This disconnect could pertain to the differences between harm reduction philosophy and reality of practice. Our findings suggest that many women appreciated the contribution of harm reduction philosophy to the atmosphere. Among other items, one should respect people, be non-judgmental, and respect the individual's right to make decisions about substance use. As a practice, however, being non-judgmental and respecting the individual's decision to use substances were found to have some negative impacts on the experience of several women. Our findings indicate that women supported the shelter's harm reduction philosophy more than some of the practices.

Most participants wanted changes made to how harm reduction is practiced in the shelter, regardless of its philosophical value. Recommendations regarding the shelter layout and monitoring are clear examples. Regardless of whether or not women used substances, greater monitoring by staff was an important recommendation. Women requested a stronger staff presence throughout the shelter, particularly in areas further removed from the office where problematic substance use behavior tended to occur. Physical layout adaptations were key to successful implementation of harm reduction in an Irish shelter (Morton et al., 2015). Our participants also suggested changes to the physical layout, with wing allocation based on whether or not women use substances or whether or not women had children with them. Regardless of the basis for division, the desired wings would reduce exposure of women and children to the problematic behaviors associated with some, but not all, women's substance use and the related actual and perceived risks to safety. Intentionally or otherwise, the recommendation would likely increase feelings of safety and more positive experiences for *all* women, thus increasing potential to achieve the goal of *all* women welcome.

Another important finding pertaining to women's perceived safety and experience were concerns about how staff handled trauma responses with a harm reduction approach. Despite practicing from a trauma-informed perspective, staff sometimes gave less credence to the voices of those who were experiencing trauma responses and complained about problematic substance use and related behaviors. At these times, staff were unable to address the traumatized person's issues and needs. Trauma-informed practice aligns well with harm reduction approaches as it emphasizes relationships that are non-judgmental, respectful, and accepting (Burke et al., 2010). As with harm reduction, staff working with trauma survivors need to promote the ability of survivors to make their own choices and have control over their own health (Burke et al., 2010; The Jean Tweed Centre, 2013). However, again, the complexities of VAW shelters can put staff in a position of having to balance competing needs of all people involved in a situation. In Julia's case, privileging the needs and voices of women who were using while dismissing Julia's needs regarding trauma symptoms, placed Julia's emotional and physical safety at risk. Regardless of how infrequently this may occur, staff must recognize when they may be creating risk for residents

by prioritizing the needs of one group of women over another. To better equip staff to balance competing needs in harm reduction shelters, particularly when dealing with women who experience trauma, further training in merging harm reduction and trauma-informed approaches may be required.

Concerns about children's safety can also be dismissed by staff for similar perceptions of judgment. Children add further complexity within VAW shelters implementing harm reduction. Morton et al. (2015) described the importance of the shelter working closely with child protection services to support both mothers and children with protection issues. Our findings emphasized the safety and protection of children. However, the understanding of the duty to report of residents and shelter staff was unclear, thus impacting the perception of safety risks and concerns for children. Although staff duty to report is communicated to residents verbally and in their handbook, actions that demonstrate staff responsiveness to child protection issues with clearer messages and processes about how child protection issues are addressed are needed. The shelter should establish supportive working relationships with child welfare officials that advocate for safety of children and capacity of mothers who are using substances to shift the focus away from a "duty to report" relationship we found.

The study is unique in its exploration of the use of harm reduction in a VAW shelter from the perspectives of women who use substances, those who formerly used substances, and those who do not use substances. There are limitations. The study was specific to a single shelter so our findings, while informative, may not be generalizable to other shelters. Particular staff- and agency-related issues arose that might have been more comprehensively addressed had we included staff interviews, but that would have changed the study's focus on women's experiences. Although we ensured the themes we identified were directly related to the substance use within the shelter, some findings might occur in shelters regardless of the use of harm reduction. That said, many findings are similar to studies about the use of harm reduction in other types of residential settings. Future research should examine women's experiences in a broader range of shelters.

CONCLUSION

Our findings support the integration of harm reduction in VAW shelters that balances harm reduction philosophy and practices with the individualized needs of traumatized women and safety of children. We recommend further research to build on the findings of our current study to examine the substance use practices of VAW shelters across the province, which may or may not align with harm reduction philosophy, and to analyze how those practices provide support and access to women who use substances. In addition to women's experiences, future studies should include the experiences of staff and agency-related experiences using harm reduction philosophy and approaches. This should be followed by development of a harm reduction framework to aid other shelters to integrate supportive substance use practices while respecting women's choice, especially Ontario shelters which must comply with their

government's standards. Finally, it is important to extend this work nationally and internationally given how minimally it has been studied.

NOTES

1. We have specific data; due to sample size and single agency source of data, we provide less explicit descriptions and the following terms represent numerical groupings of our findings to avoid identification of specific participants: Few = 1-3; Some = 4-6; Several = 7-11; About half = 12-14; Many = 15-19; Most = 20-24; All = 25; and None = 0.
2. Marijuana was not legalized in Canada when the study was completed.
3. Our findings are presented using pseudonyms for the women interviewed to ensure anonymity.

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Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Acknowledgments. The authors thank the women who took the time to share their perspectives and experiences. They thank the staff at the shelter for their assistance and support.

Funding acknowledgment: Women's College Hospital, Women's Xchange; Lakehead University, Senate Research Committee – Research Development Fund.

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APPENDIX

Semistructured interview questions:

1. We are looking at the use of harm reduction approaches in women's shelters. As you may be aware, [Shelter] uses harm reduction; for example, residents are able to be admitted to the shelter intoxicated and alcohol is allowed at the shelter. What is your understanding of harm reduction and how did you experience this at [Shelter]?
   - Note—if the participant is not clear about what harm reduction means, the following definition would be provided to facilitate her understanding and ability to respond to questions: Harm reduction is any program or policy designed to reduce substance-related harm without requiring the participants/clients to stop drug or alcohol use. The program will meet people where they are at with compassion, understanding and knowledge, providing support and resources that foster connection. For example, women will be admitted to the shelter intoxicated; alcohol is allowed at the shelter; condoms, injection/inhalation kits are provided; sharps containers are placed in each room.
   - What harm reduction approaches did you see used here? With you? With others
   - Probe regarding resources (e.g., distribution of kits), policies (e.g., allowed to use at [Shelter])
   - Based on the definition provided, how did [Shelter] staff handle the harm reduction approach?
2. How did you personally experience the harm reduction approach at [Shelter]?
   - What was positive about the experience? Can you give an example or story?
   - What, if any, concerns did you have about the experience? Can you give an example or story?
3. Do you have experience at any other shelters? If yes, when were you there? How did your experiences compare to [Shelter]?
   - What were the similarities?
   - What were the differences?
4. If you were to create the ideal shelter for abused women, what would it be like? In your opinion, how would harm reduction be implemented in the ideal shelter, if at all?

Is there any other information you would like to share about your stay(s) that I did not ask you about?