Reducing Barriers
to Support for Women Fleeing Violence

A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use

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Ministry of Health Services
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Phoenix Transition House Society
Prince George and District Elizabeth Fry Society
South Island Dispute Resolution Centre
South Peace Community Resources Society
Thompson-Cariboo Mental Health and Addiction Services
Tri City Women's Resource Society
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Vanderhoof Alcohol & Drug Services
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ABOUT BC SOCIETY OF TRANSITION HOUSES

BC Society of Transition Houses (BCSTH) is a non-profit association of Transition, Second and Third Stage Housing Program, Safe Home Programs, Children Who Witness Abuse (CWWA) Programs and other groups which serve the needs of women and their children fleeing violence. We also link schools with the CWWA program through our Violence Is Preventable (VIP) project.

Although BCSTH represents Transitional Housing programs in BC only, at the time of applying for funding for this project we also represented the Yukon Territory and hope that the Promising Practices are relevant for our former Members there as well.

Mission Statement

BC Society of Transition Houses (BCSTH) is a centre of excellence enhancing the continuum of services and strategies necessary to end violence against women, youth and children.

BCSTH works from an Intersectional Feminist Framework incorporating a critical lens to the systems of power. Without ranking, we identify power as including our experience with and ability to access systems, our social or economic status, ability, Aboriginality, citizenship/nationality, class, education, ethnicity, experience of colonization, gender, geographic location, health, occupation, refugee/immigrant status, religion and sexuality. BCSTH acknowledges that this is not exhaustive.

Some of the things we do:

- Facilitate and support services and programs for women who experience violence.
- Develop and deliver training to front line workers.
- Coordinate, train and support Children Who Witness Abuse programs (CWWA).
- Coordinate Violence is Preventable (VIP) programs in schools which link CWWA programs and educational institutions and provide support and education to young people through presentations, counselling and group interventions.
- Research and write position papers and create Promising Practices, including reducing barriers to support for women fleeing violence.
- Provide a library of resources to Members at no cost.
- Publish Communiqué, a provincial newsletter for the Violence Against Women sector.
- Engage in ongoing public education and prevention activities.
- Monitor changes to laws about violence against women, youth and children, federally and provincially.
- Advocate on behalf of our Members to government and other influential stakeholders.

SECTION 1

Introduction

Reducing Barriers
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Section 1 Table of Contents

1.1. What are Promising Practices?

We use the term "Promising Practices" to respectfully establish ideal services based on our collective experiences and expertise. Because our experiences and knowledge base are always changing, we feel the term "Promising" best reflects the useful practices that we encourage service providers to use when supporting women who have experienced violence, and who have varying levels of mental wellness and/or substance use. This toolkit reflects the commitment of BCSTH, its members and a growing number of service providers across BC to the inclusion of all women, children and youth, and to provide women-centred services that incorporate an Intersectional Feminist Framework (see Glossary in Appendix).

Part of the process of collaboratively creating and implementing Promising Practices is to reflect on our current practices, assumptions, stereotypes and uncertainties so that we do not replicate patterns of discrimination and oppression we hope to help women get respite from. We know that when women who have experienced violence are embraced by our respect and support, this will contrast with what they have fled from. This provides the strongest possible message that they do not deserve the abuse they have experienced, and meets our aim to provide and encourage services which reflect the social change that we seek in larger society—to end violence against, and to establish equality, for, all women.

1.2. Why Promising Practices for women with varying levels of mental wellness and substance use, who are at risk of violence?

In Canada, one in three women will experience violence in her lifetime. The stress and fear stemming from violent experiences can lead to chronic health problems and affect levels of mental wellness and substance use.[i] In fact, many women seeking support around their mental wellness and/or substance use have experienced violence in their lives.[ii] Our levels of mental wellness and/or substance use fluctuate in response to our circumstances and surroundings. It is no surprise that for many women, mental wellness and/or substance use fluctuate as a means of coping with violence and the feelings that arise from those experiences.[iii] This is not to say that all women with varying levels of mental health and/or substance use have experienced violence, but evidence suggests that this may frequently be the case. Yet many women with intersecting experiences of violence, mental wellness and substance use have a difficult time accessing Transition Housing. BCSTH Members and other service providers who support women have expressed a desire for tools to better serve women fleeing violence, and we have listened!

1.3. Who is this Promising Practices toolkit for?

This toolkit was originally designed for all levels of staff in agencies that operate Transition Housing programs. The information is useful and applicable, however, to service providers and organizations that support women in a variety of sectors and settings, whether housing-based or not.

A note on Safe Home programs

At the time of publishing this toolkit, Safe Home programs in BC provide women with short-term (usually 5–10 days) shelter and support services in rural and remote communities. Safe Home locations may include a

suite in an apartment building, a rented room in a hotel or motel or the private residence of a community member. Generally, these programs are supported by volunteers who help women identify and consider their options, including accessing a Transition Housing program in another community.

Because Safe Home programs are not funded to provide 24-hour support staff, are extremely short-term in duration and often support women who are still in crisis, efforts to reduce barriers may be especially challenging. While all programs will benefit from taking the time to reflect on their current policies, procedures and practices, the unique context of Safe Home programs may give rise to additional challenges for supporting women that are directly related to their limited operating resources. Still, the BCSTH members from our Safe Home pilot site found the toolkit and training useful in terms of pushing the work they were already doing even further. They were also able to use the toolkit to educate other community agencies that support women.

We hope that Safe Home programs will benefit from this toolkit and the accompanying training, but we know there is work to be done to ensure that Safe Home programs have the resources to support the women who need it most.

1.4. What is the purpose of this toolkit?

This toolkit provides Transition Housing programs, and other service providers that support women, with tools to effectively provide services to women fleeing violence who have varying levels of mental wellness and/or substance use. No one set of practices will be applicable or appropriate for every program or context, but we have identified a number of "Promising Philosophies" or promising approaches for providing services that are respectful and meaningful for women who have experienced violence. We have also included examples of how these approaches may be adopted into programming. Ultimately, this project is about moving closer to achieving our larger goal of encouraging and providing services that reflect the social change we work towards in larger society—equality and violence-free lives for all women.

The toolkit was designed to be distributed to our Members in BC and to our former Members in the Yukon Territory. It is also available in an online format on the BCSTH website. We acknowledge that each Transition Housing program, like any other service organization, operates within a unique context, which varies in response to community needs and capacity, as well as the ability of the organization to provide service. In the development of the Promising Practices toolkit we consulted with women and service providers in remote, rural and urban settings, all with different levels of access to other community support services.

This toolkit is the culmination of knowledge from women who have experienced violence and the women who supported them. In developing this Promising Practices toolkit we have drawn on the current policies, procedures and practices of BCSTH Members and non-BCSTH Members in BC; reviewed practices in Canada and internationally; and consulted with low barrier service providers and with women about what changes we might advocate for, and make.

To inform this toolkit, the Woman Abuse Response Program at BC Women's Hospital

& Health Centre facilitated group discussions and surveys with 94 women who had experienced violence in BC. Women shared how they saw connections between their experiences with violence and levels of mental wellness and/or substance use. They spoke about the challenges and positive experiences accessing Transition Housing programs and other programming in BC, as well as their ideas on how women could be better served. Quotations from these discussions are included throughout the toolkit. BCSTH also participated in discussions with 18 women with varying levels of mental health and/or substance use partway through our project, to learn whether we were moving in a direction they supported and to get additional ideas for the Promising Practices toolkit and training.

Surveys of staff in Transition Housing programs in BC were carried out by Arbor Educational & Clinical Consulting Inc., to learn about current policies, procedures and practices for supporting women with varying levels of mental wellness and/or substance use. The survey also helped us identify some of the challenges that staff in Transition Housing programs experience, and how we can support members in their efforts to reduce barriers for women. For example, some Transition Housing programs feel that they are in need of specialized knowledge to support women with varying levels of mental wellness and/or substance use. While basic knowledge in the areas of violence, mental wellness and substance use may be helpful, it is important to know that the Promising Principles and Practices that have been identified internationally are based in much of the work that you are already doing—putting women at the centre of your services by taking their lead on how you can support them best. The Promising Principles (See Section 3) and how you support women do not change based on the specific mental wellness diagnoses a woman may have or the specific substance she is using. In other words, you already have much of the specialized knowledge it takes to support women fleeing violence, whether they have varying levels of mental wellness and/or substance use or not. We hope to build on that knowledge in this toolkit.

We do not claim that simply by supporting women or focussing on a woman's experiences of violence, mental wellness and/or substance use will fall away as concerns. We are suggesting that our approach to supporting women—and our efforts to create a space where women can safely explore and speak to the connections between their experiences of violence, mental wellness and substance use—may help women feel they are in a safe space where they can explore their own experiences and goals. Evidence suggests that when supported in this way, women's substance use decreases and mental wellness increases.

We recognize that Transition Housing programs have a very short time with the women they serve. In addition, limited resources in terms of staffing and funding, as well as the communal living required in many programs, can make the work challenging. While advocating for more resources, we also need to find ways to work within these constraints to ensure that the women who are in need of safety are able to access our services. It takes time to establish trust and an open relationship. The most important thing we can do is ensure women feel they are respected and not judged negatively, regardless of their level of mental wellness and/or substance use. Establishing an environment of respect is the foundation upon which other services can be built.

1.5. How should I use this toolkit?

The toolkit is divided into four sections:

Section 1

An overview of the toolkit.

Section 2

Background information about the relationships between violence against women, mental wellness and substance use, and why it is important to provide services to women with experiences of each.

Section 3

Core principles or Promising Principles which guide the Promising Practices.

Section 4

Discussion and examples of how the Promising Principles may be applied in your work as Promising Practices. We recognize that each program operates in a unique context and within varying constraints. We encourage you, along with your team members, to identify the Promising Practices you can adopt and implement immediately, and to have ongoing conversations about how you might strive toward implementing the others.

Appendices

Additional information that will assist you in implementing the Promising Practices. Sections 3 and 4 have appendices with additional tools relevant to those sections. The final, "Reducing Barriers" Appendix contains general resources and tools to help you in your work to support women with varying levels of mental wellness and/or substance use.

We have placed reflective questions throughout the sections that we encourage you to take some time to think about, individually and with other team members in your program. The questions are also included on individual cards for you to take with you to staff or team meetings, and discuss. Engaging with the reflective questions will help you think about your current policies, procedures and practices, and how you might make changes so that these better reflect the Promising Principles and Promising Practices identified internationally.

We encourage you to review the entire toolkit and then refer back to sections as needed. We have also done our best to provide information about other resources you may find useful for supporting women with varying levels of mental wellness and/or substance use who have experienced violence.

1.6. What other resources can I draw from?

At the end of each section, we have included a list for further reading on the topics covered in that section. The Appendix also provides background for the project, additional information and resources that you may find useful.

We would like to acknowledge useful work in BC previous to this toolkit, for programs attempting to reduce barriers for women with varying levels of mental wellness and/or substance use who have experienced violence:

British Columbia Centre of Excellence for Women's Health Coalescing on Women and Substance Use Virtual Community
www.coalescing-vc.org

Ending Violence Association of BC's Freedom From Violence: Tools for Working with Trauma, Mental Health and Substance Use
www.endingviolence.org/node/459

The Woman Abuse Response Program at BC Women's Hospital & Health Centre's Building Bridges Project
www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm

1.7. Language Used in this Guide

There is a detailed glossary in the Appendix of this toolkit, and we have identified preferred language below. Language use can heavily impact our understanding of issues and may lead to misunderstandings when we are unsure of the intent behind various terms and phrases. With this in mind, we would like to supplement the information contained in the Glossary by elaborating on our use of three key terms throughout this document:

Violence Against Women[iv]

BCSTH uses the term "Violence Against Women" (VAW) as it captures all types of violence a woman may experience, including, but not limited to, domestic violence. This term captures violence a woman may experience from her partner but is also applicable to other people she may be oppressed by (family members, landlord, co-workers and broader social systems). The term can be applied to many types of harmful behaviour directed at women and girls because of their sex and gender.[v]

According to the United Nations Declaration on the Elimination of Violence Against Women, violence against women includes:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.[vi]

Control and domination are central to violence against women. A woman's experiences with violence are shaped by her social context, including her experiences with and ability to access systems, her social or economic status, ability, Aboriginality, citizenship/nationality, class, education, ethnicity, experience of colonization, gender, geographic location, health, occupation, refugee/immigrant status, religion and sexuality (this list is not exhaustive). For many women, experiences of violence precede concerns associated with mental wellness and/or substance use.

Mental Wellness

Mental wellness exists on a continuum, yet we tend to focus only on mental illness. The mental wellness continuum refers to both mental illness and mental wellness, and all the points in between. The phrase helps us remember that we are all somewhere on the continuum, therefore we all have some level of mental wellness. Mental wellness is shaped by biological, psychological and social factors. Because these factors are constantly changing, our levels of mental wellness are fluid and change in response to our environment.

Substance Use

Like mental wellness, our levels of substance use are fluid and change in response to shifting biological, psychological and social factors. Also like mental wellness, substance use is often thought of as either problematic, or not, which does not reflect the more

Instead of...	Use...	Why?
Crazy/Schizo/ Psychotic/ Nuts/Bipolar	Woman with varying levels of mental wellness/Woman impacted by mental health/Woman with mental health concerns/Women living with....	Generally, it's good practice to prioritize the person over any characteristics or behaviours they exhibit or may have, which is why we suggest "women who live with..." or "women with..." so often in this table. Calling a woman "bipolar" prioritizes her mental wellness over all other aspects of a woman's identity. "Crazy" is a derogatory term and puts responsibility on the woman for her reactions to her circumstances and experiences, rather than linking her current level of mental wellness to her experiences of violence or oppression.
Substance abuse	Substance use	It can be difficult to assess when someone is "abusing" substances and it is up to the woman to decide if this is the case. "Use" carries less stigma, and is more balanced language that can reflect a continuum of substance use practices.
Addict/Junkie/ Alcoholic	Person who uses substances	Addiction is a medical term that describes a pattern of drug use that may not describe nor feel right or like a fit for some women. In addition, these terms label a woman – the woman become her substance use rather than seeing her as an individual first and her substance use as only one characteristic.
Addiction	Substance use	Addiction is a medical term that describes a pattern of substance use that may or may not describe or feel like a fit for women. While a medical approach may feel like a good fit for some women, it can also sometimes take focus off of the many factors that contribute to a woman's varying levels of substance use. "Dependency" is sometimes used as a less stigmatising term for women who feel this type of label fits their experiences.
Clean	Not using substances/Cutting back on substance use/ Abstinent	This term associates drug use with being dirty/filthy, and abstinence with being clean.
Injection drug user	Person who injects drugs	In general, our terminology should prioritize the person over their use of substances. Putting the word "person" here emphasis that we are talking about a person who uses drugs, rather than equating the person with their use of substances.
User	Person who uses substances	"Person who uses substances" acknowledges that a woman is a person with many characteristics first, and acknowledges that substance use is only one part of a woman's life.

complicated continuum of substance use. We use the term "substance use" to refer to the broad continuum of substance use. Where we are on the continuum does not necessarily depend on the substance we are using. Although the harmful health effects of illicit substances tend to appear more quickly than the effects of some legal substances, such as alcohol and tobacco, the latter can have lethal long-term health consequences as well. It is also possible to overdose on prescribed medications or to become overly reliant on a legal substance, like caffeine. The legality of a substance does not necessarily predict where we fall on the continuum, nor does the legality of a substance ensure that there will be no harmful consequences.

Rather than using the rather lengthy term "women with varying levels of mental wellness and/or substance use," we have tried as much as possible to just use "women" in this document. This abbreviation is an effort to make the document more readable but also to remember that the principles and practices in this toolkit are useful for any woman we are supporting. We avoid using terms like "problematic substance use" or "mental illness" because we feel that women are often labelled with these terms with little consideration for whether they feel the labels fit. While some women feel clinical diagnoses fit well and explain their experiences, others may not. Our best option, when working with women, is to explore the language they prefer. Our intention is to build women-centred practices, even with the use of our language.

Defining when mental wellness and/or substance use are problematic can be challenging, especially when considering that levels may fluctuate as women attempt to cope with the violence they experience.[vii] Rather than attempting to determine whether women need support around mental wellness and/or substance use, these Promising Practices encourage workers to ask women what they need from us, and to focus on meeting women's needs as they identify those needs. This practice is the foundation of, and essential to, providing women centred services and support.

We emphasize that mental wellness and substance use are not problems themselves and we must consider what problems are created by our levels of mental wellness and substance use.

In addition to these key terms, we have made some suggestions on the opposite page about respectful, non stigmatising language. We also encourage you to avoid terms or acronyms that may not be widely used or that may feel like "jargon" to women accessing support. Language can change, though, and we encourage you to use the language the woman you are serving is comfortable with.

i Substances include illegal and legal substances, including prescription or non-prescription medications.

ii Poole, N. (2007). Interconnections Among Women's Health, Violence and Substance Use: Findings from the Aurora Centre. In Poole, N. and Greaves, L. (Eds.). Highs and Lows: Canadian Perspectives on Women and Substance Use. Toronto, ON: Centre for Addictions and Mental Health.
Firsten, T. (1991). Violence in the Lives of Women on Psychiatric Wards. Canadian Women's Studies/Les Cahiers de la Femme, 11(4), 46.

iii Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. (2006). Women, Mental Health and Mental Illness and Addiction in Canada: An Overview. http://www.cwhn.ca/PDF/womenMentalHealth.pdf

iv Salerno, J., Membership Working Group. (2010). Violence Against Women Framework for Transition, Second and Third Stage Houses and Safe Homes.

v Hightower, J. and Smith, G. (2002). Silent and Invisible: What's Age Got to Do with It? A Handbook for Service Providers Working with Abused Older Women. Vancouver, BC: BC Society of Transition Houses.

vi Division for the Advancement of Women, United Nations. (1995). The United Nations Fourth World Conference on Women Section D. Retrieved January 12, 2010 from http://www.un.org/womenwatch/daw/beijing/platform/violence.htm#object1

vii World Health Organization. (2000). Women's Mental Health: An Evidence Based Review. Geneva: Department of Mental Health and Substance Dependence.

SECTION 2

Violence Against Women, Mental Wellness and/or Substance Use

Reducing Barriers to Support for Women Fleeing Violence

A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use

Section 2 Table of Contents

Section 2 Summary

Connections Between Violence Against Women, Mental Wellness and/or Substance Use

Violence against women, mental wellness and/or substance use are deeply connected.

For many women, changes in mental wellness and substance use are a response to experiences of violence:

- Changes in levels of mental wellness may be seen as a normal response to violence.
- Many women report using substances to cope with violence and other stressors in their lives (such as poverty, inadequate housing, lack of affordable childcare).

Women we consulted with in BC say that most services do not create space for women to explore or talk about these connections.

We often make assumptions about what women who have varying levels of mental wellness and/or substance use are like, how they will behave, or how they will/will not fit with our program.

Women may experience even more stigma and judgement based on their social locations or social identities.

Take time to reflect on where these ideas come from, and how they might impact your work.

There are benefits and drawbacks to accessing support for mental wellness and/or substance use for women fleeing violence. Women may:

- be at an increased risk of violence from the abuser
- experience severe withdrawal symptoms from substances
- be prescribed substances that dull her senses and make it hard for her to gauge her safety.

Women report feeling that they cannot be open or truthful with service providers for fear of being asked to leave because of their mental wellness and/or substance use.

These conditions go against creating a safe, open and welcoming environment for women who have fled violence, and may feel more like another abusive environment.

Section 2 Summary Continued..

How might our services be more reflective and responsive to the realities of women in a way that counters dynamics of power and control?

Human rights legislation prohibits service providers from turning women away solely based on their levels of mental wellness and substance use.

How might we shift our focus to behaviours, rather than levels of mental wellness and/or substance use alone?

Resource limitations are a real problem, but we have a responsibility to do what we can, with what we have, to support the women who need support the most.

Section 2 Reflective Questions

1. How have you seen the connections between violence against women, mental wellness and/or substance use in your work?
2. What effects might violence have on a woman's mental wellness?
3. What are some reasons women use substances?
4. What do you do to cope with feelings or situations/experience pleasure/out of habit? Are some of these things healthier than others? Would some of the healthier methods be available to women who are experiencing violence? How hard would it be to give any of them up tomorrow?[i]
5. What are some common beliefs about women who use substances?
   What are some common beliefs about women who have varying levels of mental wellness?
   How do these beliefs affect our work with women fleeing violence?
   How might our own experiences with mental wellness and/or substance use affect our work with women fleeing violence?
6. What do we mean when we say "safety issues"? What do safety issues look like?
7. Aside from mental wellness and/or substance use, what might lead to or explain the following behaviours? (See page 32 for possible responses.)
   - Nodding off.
   - Incoherence.
   - Swearing.
   - Anger or rage reactions.
8. Is it harmful for women, youth and children fleeing violence to be around women who use substances or who have varying levels of mental wellness? How so, or how not?
9. How might a woman benefit from choosing not to access support for mental wellness? What might some of the costs be for a woman who decided to access support for her mental wellness?
   What are the benefits a woman who has experienced violence may get from using substances?
   What are the costs a woman who has experienced violence may encounter, if she cuts back on or stops using substances?

Section 2 Reflective Questions Continued..

10. Where do our ideas of what a ”normal” woman looks and behaves like, come from? Where do our ideas about women with varying levels of mental wellness and/or substance use come from? How are these ideas connected to sexism, racism or classism?
11. What reasons might a woman with varying levels of mental wellness and/or substance use have for not accessing your Transitional Housing program? Can you think of ways to make it easier for women to access safety and support?
12. What factors might make women from various backgrounds and contexts with varying levels of mental wellness and/or substance use, hesitant to access support around violence, mental wellness and/or substance use? What changes can you make to reduce these hesitancies?
13. What gets in the way of providing services and support to women with varying levels of mental wellness and/or substance use? What are some ways you have found to work around or through those challenges? How can you build on those efforts?

2.1. Connections Between Violence Against Women, Mental Wellness and/or Substance Use

[A]s many as 2/3 of women with substance use problems report a concurrent mental health problems, often related their experiences of surviving physical and sexual abuse as children or adults.

– British Columbia Centre of Excellence for Women's Health[ii]

In Canada, one in three women will experience violence in their lifetime. Violence against women is the most frequent cause of injury to women in our country.[iii] The stress and fear stemming from experiences with violence can affect women's bodies and minds, and can influence levels of mental wellness and/or substance use as women cope with the violence and its effects.

Some impacts women who have experienced violence describe include[iv]:

- Exhaustion/Fatigue
- Insomnia
- Changes in appetite
- Dizziness/Nausea
- Chronic pain
- Depression
- Headaches/Migraines
- Digestive problems
- Sexually transmitted infections
- Confusion
- Lack of concentration
- Memory loss
- Feeling "crazy"
- Feeling suicidal
- Anxiety
- Feeling incapable/incompetent
- Feeling vulnerable
- Intense rage
- Increased smoking/drinking
- Needing prescription drugs to cope, sleep etc.
- Afraid to make decisions

Women, anti-violence advocates, workers in the mental wellness and/or substance use sectors, and researchers have been increasingly calling attention to the connections between violence, mental wellness and/or substance use in recent years. Yet, services in the violence against women, mental wellness and/or substance use sectors are not always responsive to these connections. Women are often required to seek support from multiple service agencies that offer support around one area of concern, even though women say their experiences of violence, mental wellness and/or substance use are deeply connected. For example, in focus groups conducted by the Woman Abuse Response Program at BC Women's Hospital & Health Centre for the Reducing Barriers project, women who had accessed Transitional Housing programs spoke of the effects violence can have on mental wellness and/or substance use and the lack of coordinated responses:

Sometimes there are those days, these days where I just don't want to wake up in the morning because I am like what is the point. ... And when that happens why can't we have someone from mental health come around and be able to help? Because you know when you get depressed you can't get up even though you need to you can't.

– Woman in Reducing Barriers Focus Group

Clearly, there are ways we can improve our services for women who have experienced violence.

The connections between violence, mental

wellness and/or substance use are complex. Women who have varying levels of mental wellness and/or substance use are more likely to experience violence. But for many women, mental wellness and/or substance use fluctuate in response to experiences of violence. Experiences with other forms of stressors and oppression (such as poverty, racism, homophobia, ableism, ageism) can also contribute to mental wellness and substance use concerns.[v] The links between violence and mental wellness, and violence and substance use, are explored in greater detail below.

Reflective Questions

How have you seen the connections between violence against women, mental wellness and/or substance use in your work?

2.1.1. Mental Wellness and Violence Against Women

Many trauma survivors who sought mental health services have been given more than one diagnosis (at the same time) to describe their difficulties, such as bipolar disorder, schizophrenia– paranoid type and borderline personality disorder. .... Traditional psychiatric diagnoses do not consider the context (for example, traumatic event/s) in which a person may have developed these responses; in other words, many "symptoms" that women exhibit represent their attempts to cope with and adapt to traumatic stress. These diagnoses focus on what is "wrong" with this person, rather than on what horrible things have happened to this person. – *Lori Haskell*[vi]

Reflective Questions

What effects might violence have on a woman's mental wellness?

Though we tend to focus on either mental illness or mental health in discussions of our mental well-being, we are all somewhere on the continuum of mental wellness. Our levels of mental wellness fluctuate and are constantly changing in response to our social circumstances, our access to support networks and biological influences. Women may experience changes due to a number of factors, but experiences with violence can have significant effects on mental wellness. In fact, research shows that most women who access services for concerns around their mental well-being have experienced violence at some point in their lives.[vii]

Domestic violence and other abuse is the most common cause of depression and other mental health difficulties in women.

– *Greater London Domestic Violence Project*[viii]

Experiences with violence, other forms of oppression and significant stressors can actually change the structure of the brain and the way it functions, which in turn can alter our levels of mental wellness. Researchers looking at how brain functioning changes in response to violence describe a shift from a brain (and body) that focuses on learning and engaging with the environment "...to a brain (and body) focused on survival." In this survival state, the brain tries "...to anticipate, prevent, or protect against the damage caused by potential or actual dangers...."[ix] Simply put, when women experience ongoing violence the brain adapts so that core areas in the brain that help us to

perceive and respond to threats are engaged, while activity in areas of the brain that are required for more complex processes, like emotion awareness, problem solving, planning and relationship building, are reduced.[x] These changes in neural pathways affect women's personalities and emotions, and can lead women to consciously and unconsciously (or automatically) avoid forming relationships in order to prevent further harm.

To describe the "complex set of responses that [may] follow...chronic, multiple and/or ongoing traumatic events" like experiences with violence, researchers have coined the term Complex Post Traumatic Stress responses.[xi] Complex Post Traumatic Stress responses are different from Simple Post Traumatic Stress responses, which are in reaction to a one-time event; but women who have experienced long term violence may be impacted by both.

Post-traumatic stress is referred to as Post-traumatic Stress Disorder (ptsd) in the clinical literature... it is important to recognize that the effects and symptoms of abuse-related trauma are themselves normal responses. They are ways of coping with the harm inflicted by the abuse.

– Lori Haskell[xii]

Some Simple Post Traumatic Stress responses:[xiii]

- Intrusive re-experiencing of the trauma.
- Numbing.
- Hyperarousal (such as insomnia, startled reactions, irritability).

Some Complex Post Traumatic Stress responses:

- Depression.
- Self-hatred.
- Difficulties with emotions and impulses.
- Aggression against self, and other self-destructive behaviour.
- Dissociative responses.
- Inability to develop and maintain satisfying relationships.
- Loss of meaning and hope.

For many women, these psychological impacts of violence are more severe and long lasting than physical impacts.[xiv] But sometimes, the connections between mental wellness and violence are lost. Researchers in BC have noted that women are more likely to receive mood disorder labels (depression, bipolar disorder, anxiety disorders, seasonal affective disorders) than are men,[xv] and women are prescribed medications for depression and anxiety medications more than any other medication.[xvi] Anti-anxiety medications such as tranquilizers and benzodiazepines may help women feel less anxious, but for some women these medications get in the way of assessing their safety. In addition, benzodiazepines can be very difficult to stop using and may have harmful withdrawal side effects (such as seizures). Rather than attribute discrep-ancies in levels of diagnoses to biological factors, Morrow and Chappell speak to the role that social inequities have on mental wellness, saying that "[f]or many women social conditions of inequity, in particular experiences of violence, precipitated their entry into the mental health system."[xvii]

We cannot ignore or gloss over medical or mental wellness diagnoses, and not all women who have varying levels of mental wellness have experienced violence; but we need to be careful about the assumptions we make, and associations often made with "labels" related to mental well-being. Focusing on diagnostic labels at the expense of all other aspects of a woman can lead us to pathologize and dismiss the woman,

rather than focussing on what has lead to the fluctuations in mental wellness—often, it is experiences of violence. The effects on mental well-ness listed above are not necessarily permanent and may be reversed through various means, including meaningful attachments that counter those with characteristics of violence, control, coercion and abuse.

Barriers to Service for Women with Varying Levels of Mental Wellness

The impact that experiences of violence have on our mental well-being can make it challenging for women to seek out support. Some women who experience severe anxiety may be unable to leave their own homes, let alone engage in communal living in Transitional Housing programs. Transitional Housing policies, procedures and practices can also create barriers for women, as many programs in BC require women to take medication, undergo a thorough assessment and have contact with service providers in the mental wellness sector if women disclose any mental concerns about their mental well-being.[xviii] In addition, women who use substances to cope with the violence and its effects on mental wellness often cannot gain admission to Transitional Housing programs in BC because of policies requiring women to abstain from substance use both for a certain time period before, and during, their stay at the program.[xix]

More than 70 percent of people with Post Traumatic Stress Disorder (PTSD) are women, and those with PTSD are 3-5 times more likely to use substances.

– Anti-violence researchers and advocates J. Cory, L. Dechief & E. Poag[xx]

One study compared rates of clinical diagnoses between women who had experienced violence and women who had not. Fifty percent of the women who experienced violence had a clinical diagnosis related to mental wellness, while only twenty percent of women who had not experienced violence had a clinical diagnosis.

– Mental health researchers A. Ledermir, L. Schraiber & A. D'Oliveira[xxi]

For detailed descriptions of various mental wellness diagnoses and how they are connected to violence, see Sane Responses: Good Practice Guidelines for Domestic Violence and Mental Health Services (2008) from Against Violence & Abuse in the UK **www.avaproject.org.uk/media/27099/mental%20health%20a5%20section%202.pdf**

2.1.2. Substance Use and Violence Against Women

I have had that sometimes. I drank I am not going to lie. Sometimes I drank to relax and then there are times I tried to read. I tried meditation and watched TV but then there are times that I needed a release. I started wandering towards using.

– Woman in Reducing Barriers Focus Group

Reflective Questions

What are some reasons women use substances? (After thinking about this, see some reasons on opposite page.)

Researchers are finding significant overlap between experiences with violence, and substance use. For example, 86 percent of women seeking treatment for substance use at Aurora Centre at BC Women's Hospital & Health Centre reported on their intake forms that they had experienced some form of violence, at some point in their lives.[xxii] Because many women do not fill in sensitive information on intake forms, the actual number may be even higher. As with mental wellness, our levels of substance use are fluid and constantly changing in response to social, biological and psychological factors, and violence is one factor that can affect women's levels of substance use.

Women who have experienced violence may use substances, legal and illegal, for a variety of reasons. Some women use substances as a way to avoid violence from an abuser who is pressuring her to use the substances. Abusers may encourage women's substance use as a means to gain more control over them—by having more influence over their behaviour and/or control over their access to substances. Women may also take substances, prescribed or not, to cope with the physical and psychological effects of violence. Even when substances are prescribed, women may become dependent on them and may find it hard to cut back on, or stop, their use.

Reasons Women Use Substances:[xxiii]

- To feel in control.
- To cope with violence or other stressors.
- To relieve emotional or physical pain.
- Forced by partner/to keep partner happy.
- To release anger/frustration.
- To make sex easier if are uninterested or have had bad experiences.
- To control withdrawal symptoms.
- For fun.
- To be social.
- To be accepted.
- Out of habit.
- Prescribed by a doctor.

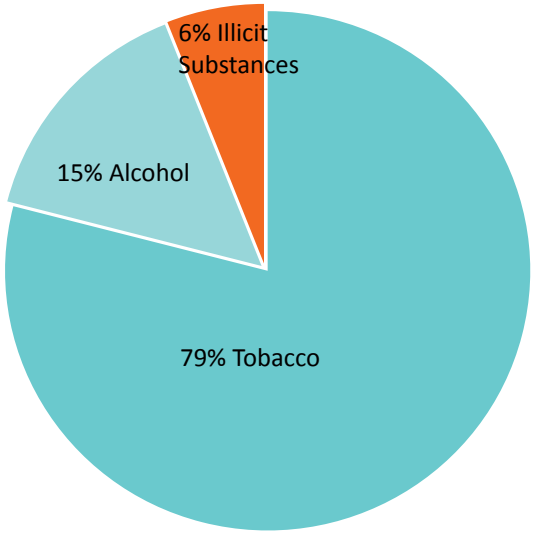
Many women use substances, legal or illegal, as a way to cope with the violence and the resulting effects on their sense of mental well-being. For example, after surveying women in a number of BC Transitional Houses, researchers with the BC Centre of Excellence for Women's Health (BCCEWH) found that the number one reason women gave for using alcohol, was to cope.[xxiv] Women may be coping with the violence, mental wellness impacts of violence, or a number of other stressors in their lives—including those around housing, income assistance and transportation. Supporting women who use substances can reduce stress, and in turn, reduce levels of substance use. In the BCCEWH research, women who accessed support through a Transitional Housing program reported a decrease in their use of alcohol and were less likely to identify their substance use as a concern, even when they received little support around the substance use specifically.

Substances, whether legal or not, can have various positive and negative effects on our behaviour. Yet we often presume that illegal substances lead to negative effects, and legal substances (such as prescriptions) bring positive results. The legal status of a substance plays a role in how we perceive the substance (dangerous vs. helpful), but also in our perception of the woman using the substance. In reality, a substance's legal status is not always a predictor of its health consequences on women. Illegal substances may have more immediate effects on health, but legal substances (such as tobacco and alcohol) can have harmful long term effects. As such, we cannot automatically equate use of illegal substances with problem substance

use, "addiction" or pathology. Nor can we assume that a woman's use of legal substances, including prescriptions, is necessarily beneficial or in the woman's best interests.

The Centre of Addictions Research of BC estimates that from 2002 to 2006 there were 1,814 deaths caused by illegal substance use, 4,431 deaths caused by alcohol use and 22,872 caused by tobacco use in the general population.[xxv]

Estimated number of substance caused deaths from 2002-2006 in the general population in BC.



Barriers to Service

Women who wish to access Transitional Housing programs in BC are almost always required to abstain from substance use (including alcohol) while in the program. In addition, policies often require that women not have used substances for a certain amount of time before accessing services and safe shelter.[xxvi] This can be dangerous for women as we are making access to service dependent on abandoning coping strategies that may have been effective for them. For some women, stopping substance use altogether is not an option, and may leave them vulnerable to further violence or harm. As a woman cuts back on her substance use she may actually experience increased violence from her abuser, if they feel they are losing control over her. Suddenly stopping long term use of alcohol or benzodiazepines, may also leave a woman at risk of seizures or even death.

[D]omestic violence program[s]... typically require a substance abuse evaluation and compliance with any subsequent treatment plan that might be recommended. The implicit expectation is often that women will proceed in linear fashion to the end goal- abstinence and recovery- an expectation no more realistic than to expect a battered woman to leave her abusive partner the first time she reaches out for help. – Theresa Zubretsky[xxvii]

Requiring women to abstain from substance use to access services puts women in a position where they may feel they cannot be truthful with, nor trust, Transition Housing workers. Women may feel negatively judged for coping in the way they do, and because of that, may think anti-violence advocates do not understand their experiences with violence. Abstinence rules do not allow women to make their own decisions around their substance use, in their own time, and may be experienced as yet another form of disempowerment. While we may provide information and options in a nonjudgmental way, women must be able to make informed decisions on their own time and their own terms. Creating a non-judgmental and supportive space for women provides women

with the ability to talk about their substance use, which is integral to realistic safety planning processes.

Reflective Questions

What do you do:

- to cope with feelings or situations?
- to experience pleasure?
- out of habit?

Now ask yourself these questions:

- Are some of these things healthier than others?
- Would some of the healthier methods be available to women who are experiencing violence?
- How hard would it be to give any of them up tomorrow?[xxviii]

2.2. Beliefs About Women Fleeing Violence, Mental Wellness and/or Substance Use

Reflective Questions

What are some common beliefs about women who use substances?

What are some common beliefs about women who have varying levels of mental wellness?

How do these beliefs affect our work with women fleeing violence?

How might our own experiences with mental wellness and/or substance use affect our work with women fleeing violence?

Many people believe all substance users are unruly, violent, rude and inconsiderate. These beliefs are generally unfounded and based on the notion that drugs are bad and so are the people who use them. For some women substances in fact make them more subdued, withdrawn and make them act and behave normally. The latter circumstance illustrates how substances can be used as a coping mechanism. We all make choices about our behaviour whether under the influence of substances or not. Substance use does not excuse or cause violent or offensive behaviour.

– *Greater London Domestic Violence Project*[xxix]

Women who experience violence encounter a great amount of stigma in our society. This stigma is compounded when women have varying levels of mental wellness and/or substance use. Rather than seeing fluctuations in levels of mental wellness and/or substance use as a logical and normal response to experiences of violence, women with these responses are often seen as abnormal, strange and sometime even dangerous. This is especially true when a woman has children, or is around children in the Transition Housing program setting.

A recent study in the UK found that two-thirds of people felt people with schizophrenia were dangerous to others. Three-quarters felt the same way about people who use substances. – *Researchers A. Crisp, M Gelder, E. Goddard and H. Meltzer*[xxx]

When asked why women with varying levels of mental wellness and substance use are not admitted to many Transition Housing programs in BC, most ant-violence workers reply by saying “it’s a safety issue.” Descriptions of what are often deemed safety issues

that arise when women are accepted into programs often include things like women nodding off, swearing or using "street language," hiding paraphernalia related to illegal substances, and behaviours better described as unpredictable rather than dangerous.

Reflective Questions

What do we mean when we say "safety issues"? What do safety issues look like?

Although mental wellness and substance use fluctuate independently of experiences of violence, many behaviours can also be situated as normal responses for women who are in crisis and who are staying in communal living environments. Secrecy and hiding things can be seen as normal responses to the circumstances a woman finds herself in. Women who must choose between either a) telling the truth about her levels of mental wellness and/or substance use, and subsequently not gaining access to/being asked to leave a Transition Housing program, or b) lying and gaining access to a program, will choose the option they believe will keep them safer.

From focus groups and surveys conducted as part of this project by the Woman Abuse Response Program at BC Women's Hospital & Health Centre, we know that many women currently accessing Transition Housing programs have varying levels of mental wellness and/or substance use—they just do not talk about it for fear of being asked to leave. In other words, we are already serving women with varying levels of mental wellness and/or substance use. Many of the more mundane, non-problematic experiences with women are not recognized or shared. Unfortunately, it also means that many women are experiencing an environment of secrecy, mistrust, tension, guilt and shame in many Transition Housing programs—an environment similar in many ways to those that women who have experienced violence are seeking reprieve from.

In an environment where women are unable to speak about how violence has had an impact on their levels of mental wellness and/or substance use, and where they feel they may actually experience judgement or homelessness if they do, women may feel a variety of things—guilt, shame, anger, frustration—that can manifest in behaviours often seen as problematic or unsafe.

I just had to keep knocking on doors to get someone to open them I just had to keep trying. I yelled and screamed I phoned I did everything. Where is the information? There isn't any until you start screaming bloody hell… -*Woman, Reducing Barriers Focus Group*

Anger and yelling and other behaviours that may be seen as "disruptive" sometimes have more to do with the feelings that result from what women see as an unfriendly environment for them, rather than their levels of mental wellness and/or substance use. Still, if Transition Housing program staff discover that women have not been truthful, the behaviours—including the untruthfulness—are often attributed to the women's mental wellness and/or substance use. This can produce a vicious circle, and resulting assumptions have grave implications for other women who may attempt to access the program and who are open about their levels of mental wellness and/or substance use. It also means that opportunities for learning and improving our services to women have been lost.

Going to a Transition Housing Program for support is a difficult choice

for a woman to make. If she does not feel respected and fully supported when she is there she may leave and never make that choice again.

Reflective Questions

Aside from mental wellness and/or substance use, what might lead to or explain the following behaviours?

- Nodding off.
- Incoherence.
- Swearing.
- Anger or rage.

See page 32 for some ideas.

Signs of prejudice towards people with varying levels of mental wellness and/ or substance use:[xxxi]

- Stereotyping (treating women as a group or a label rather than an individual).
- Trivializing the women's concerns or experiences.
- Belittling the women or offending them through insults.
- Patronizing women, by treating them as less worthy of services than women who may not be perceived to have problems with mental wellness and/or substance use.
- Reinforcing common myths (such as "dangerous," "weak," "beyond hope") about people with varying levels of mental wellness and/or substance use.
- Labelling women by their mental wellness and/or substance use (such as "paranoid schizophrenic," "addict"); the concept of the person as an individual, is lost.
- Using slang words (such as "crazy," "schizo," "alchy." "crackhead").
- Sensationalizing or accentuating myths (such as passing along harmful stories about the women heard from other workers, that were not actually personally experienced)

Due in part to the social perceptions of women who have varying levels of mental wellness and/or substance use, women fleeing violence may experience a wide range of barriers to support when attempting to access services. Focussing specifically on Transition Housing programs in BC, women in the Reducing Barriers focus groups identified barriers to support in Transition Housing programs:

- Judgement/stigma on the part of service providers.
- Fear that children will be apprehended because of violence, mental wellness and/or substance use.
- Prioritizing the safety of women who are perceived as not having problems related to mental wellness and/or substance use.
- Unrealistic expectations requiring a woman not have used substances for a period of time before entering the Transitional Housing program.
- Requiring a woman to attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) when she does not feel these are beneficial to her.
- Lack of cooperative or collaborative services—not able to get support around more than one issue in one place.
- Requiring a woman to take/monitoring a woman's prescribed medications.

In order to stay at that house...I had to do NA [Narcotics Anonymous] and AA [Alcoholics Anonymous] even though I was not drinking, and I had to go see a D & A [Drug and Alcohol] counselor and a regular counselor just to stay at the house.

You know, like, yeah it was nice they were helping, but I don't understand AA when I am not drinking—and they kind of pushed me in a direction that was not really suitable for me at the time. But in order to stay somewhere safe and away from him, away from drugs, that is what I had to do. So it was either go back to that, or do this stuff that I did not really need to do.

– *Woman in Reducing Barriers Focus Group*

Often, Transition Housing program staff who feel unable to accept a woman into the program because of her levels of mental wellness and/or substance use, refer her to other services. But women in the Reducing Barriers focus groups also identified a number of barriers to services in the mental health and substance use fields:

- Judgement/stigma on the part of the service provider.
- Lack of understanding about violence against women, which in turn leads to inappropriate services/recommendations or puts women at further risk of violence.
- Experiences of increased risk of violence when cutting back on/reducing substance use or seeking support around mental wellness, because abuser feels they have less control over the woman.
- Services further disempower women/reproduce abusive relationships.
- Fears that children will be apprehended because of violence, mental wellness and/or substance use.
- Feelings of powerlessness/not being included in their own health care planning.

Women often face barriers no matter which service they are referred to. When speaking about positive experiences, women were less concerned about the sector the support came from, and more concerned about the type of support they got. Rather than referring to "specialized knowledge,", women spoke most about the welcoming, non-judgemental and supportive attitudes which they felt created an atmosphere where they could openly talk about the violence they had experienced, and its impacts on their mental wellness and/or substance use.

Many Transition Housing program staff members worry that accepting women with varying levels of mental wellness and/or substance use into the program, will prevent other women from accessing their services. Yet most women in the Reducing Barriers focus groups and surveys, who have accessed Transition Housing programs, said outright they were not concerned about living with women who have varying levels of mental wellness and/or substance use.

I had no concerns about other women and youth except these residents were being abused by the Transition House staff… by [someone] who herself displayed severe mental health symptoms… This left all residents with no mental safety at the house.
– *Women in Reducing Barriers Focus Group*

Other women who said they did initially have hesitancies, acknowledged that their hesitancies and fears dissipated once they were around women they perceived as having varying levels of mental wellness and/or substance use. Overall, most women said they felt it was essential that all women have a safe space where they could go when experiencing violence.

And you think of a woman going back out into an unknown situation, whether they go back to the abusive man or they go some scary place. They might be living in an addiction and only

know places, you know, that are unsafe. And then those beds are just sitting there empty [t] hat could have been accessed by somebody that…might not be severely under the influence, they might be just a little intoxicated; like, if they are belligerent and everything then [they could be] asked to leave. But I think they should have access, even if they are under the influence.
– *Woman in Reducing Barriers Focus Group*

Safety concerns are cited most when children are in the Transition Housing program. Again, it is important to distinguish what is a safety concern, from what may just be seen as unusual behaviour. Most women do not want to put youth and children in unsafe situations. Many of the service providers we consulted during the course of this project spoke of experiences where women were more careful, and more likely to self-censor, when youth and children were around. Women who have children go to great lengths to keep them safe, regardless of their levels of mental wellness and/or substance use. For example, some women use substances as a means to keep their partners happy, which may prevent violence towards themselves and their children.

The low barrier housing programs we consulted with in the creation of this toolkit were hard pressed to recall any instances where the safety of women, children or staff was in jeopardy. They credited the open, non-judgemental environment where women did not feel further degraded or that they had to be secretive – feelings they were trying to escape by going to a Transition House program.

Women with children are caught between a rock and hard place when it comes to violence, mental wellness and/or substance use: they may be more inclined to seek support for each, but when they do, may experience judgement because they have children, and subsequently may have their children removed. Yet women who have lost their children to Children's Service agencies often report even more problems associated with mental wellness and/or substance use. And having a child apprehended for mental wellness and/or substance use reasons can make it difficult for a woman to gain custody down the line. For these reasons, women are often hesitant to seek support for fear that their children will be taken away. For Aboriginal women and women of colour who often face many layers of discrimination related to sexism, racism and colonialism, these fears are reinforced by high rates of child apprehension.

Women who are Aboriginal are 20 times more likely to have their children apprehended than any other group of Mothers. In fact, there are three times more children who are Aboriginal in the care of child welfare agencies now than there were in residential schools at the height of their operations.
– *Assembly of First Nations*[xxxii]

Reflective Questions

Is it harmful for women, youth and children fleeing violence to be around women who have varying levels of mental wellness and/or substance use? How so, or how not?

It is often believed the best possible thing is for women to be on medication for/receiving treatment for mental wellness, or in terms of substance use, not to use substances at all (to abstain). But there are benefits and costs to everything we do—including seeking support,

or choosing not to seek support for mental wellness or substance use. Often we tend to think only of the costs associated with continuing to live without support; not taking medications for mental wellness; or continuing to use substances. Similarly, we tend only to think of the benefits of taking medications; cutting down or stopping substance use; and seeking support for either. But these focuses come at the expense of a more balanced and realistic picture. For example, many medications for varying levels of mental wellness cause a sense of numbness, disconnection and/or drowsiness—side effects which make becoming/staying safe from violence, problematic. And as we discussed before, women may be at increased risk of violence from their abuser when they seek support.

Reflective Questions[xxxiii]

How might a woman benefit from choosing not to access support for mental wellness? What might some of the costs be for a woman who decides to access support for her mental wellness?

What are the benefits a woman who has experienced violence may get from using substances? What are the costs a woman who has experienced violence may encounter if she cuts back on, or stops, using substances?

We live in a world full of stereotypes and biases related to mental wellness and/or substance use. These biases and stereotypes are also informed by other factors related to social or economic status, ability, Aboriginality, citizenship/nationality, class, education, ethnicity, experiences of colonization, gender, geographic location, health, occupation, refugee/immigrant status, religion and sexuality (this list is not exhaustive). We have a lot to unlearn, and this takes time and commitment. As anti-violence advocates, it is our responsibility to reflect on our assumptions, stereotypes and fears so that we do not replicate the patterns of discrimination and oppression we are hoping to help women get respite from.

Reflective Questions

Where do our ideas of what a ”normal” woman looks and behaves like come from?

Where do our ideas about women with varying levels of mental wellness and substance use come from?

How are these ideas connected to sexism, racism, classism?

Whatever a woman’s levels of mental wellness and/or substance use, as women-centred service providers the services and referrals we provide are based on what women ask for. Rather than trying to determine whether a woman has ”issues” related to mental wellness and/or substance use, a woman-centred approach requires us to ask women what areas they would like support around, and to collaboratively plan from there. Taking the time to build a relationship based on respect, and acknowledging and addressing power imbalances, will help build trust between you and the women you support—and ensure they are able to talk to you openly about what they want support around. This requires a different way of thinking and doing our work every day, and involves partnering with a woman to walk with her down the paths she chooses rather than leading her in any one direction.

Respectful, nonjudgmental services will reaffirm a woman’s decision to seek support and to do so again if she needs it in the future. This can include:

- *being engaged and there for each woman who enters the program*
- *focussing on what she wants support for, rather than identifying areas of support for her*
- *using respectful tone and language*
- *recognizing and honouring the strengths of each woman you see*

See Freedom From Violence, a toolkit from Ending Violence Association, Section 1.3 for further discussion of societal views around mental wellness and substance use.

Reflective Question

What reasons might a woman with varying levels of mental wellness and/or substance use have for not accessing your Transition Housing program? Can you think of ways to make it easier for women to access safety and support?

2.3. The Importance of Social Context

Providing suitable services to women who experience the greatest barriers to service is [a] significant challenge. Despite our diverse population in BC (especially in urban areas), services are provided primarily in English, are not often suitable for all age ranges of women, rarely make accommodation for physical and mental health issues, are often Euro-centric, and are primarily aimed at heterosexuals.

– Minister's Advisory Council on Women's Health[xxxiv]

As with any other systems, the anti-violence sector can be experienced differently depending on the social context of the women accessing services. In fact, service recipients, providers and researchers have consistently highlighted the need for anti-violence programming to be based on the experiences of the women accessing the services.[xxxv] To best understand how violence, mental wellness and substance use impact women, the social context in which a woman lives must be taken into consideration. In addition, the various points of oppression that exist in our society must be taken into account (such as sexism, racism, colonialism, classism, homophobia, transphobia). Levels of mental wellness and substance use may be influenced by the violence one experiences, and compounded by experiences with discrimination and oppression related to women's various social locations or identities. To reduce barriers to service, activists urge agencies to engage in ongoing "organizational critical self-examination" of their policies, procedures and everyday practices to ensure they are inclusive, and that services will lead to social change rather than reproduce women's inequality.[xxxvi]

Reflective Question

What factors might make women from various backgrounds and contexts, with varying levels of mental wellness and/or substance use, hesitant to access support? What changes can you make to reduce these hesitancies?

Think about how a woman with varying levels of mental wellness and substance use might experience accessing a Transition Housing program if she also:

- has a disability/ies
- lives on the streets
- earns less than $10,000/year
- earns more than $100,000/year
- earns between $10,000 and $100,000/year

- is Aboriginal and lives on reserve
- is Aboriginal and does not live on reserve
- recently immigrated to Canada
- came to Canada as a refugee
- has no immigration status in Canada
- did not complete high school
- has a graduate degree
- is a sex worker by choice
- is a survival sex worker
- is a woman of colour
- has children with her
- has children who have been taken from her custody
- identifies as a transgender woman
- identifies as lesbian, bisexual or queer
- lives in a rural or remote area
- knows the staff at the Transition House because she lives in a small community
- lives in an urban city
- has HIV or AIDS
- practices Islam
- is an atheist.

Abilities

"When you have a disability, you need assistance for things of daily living. Most of us accept a lot of things because we need assistance. We accept too many unacceptable things."

– Woman in DAWN Focus Groups, 2011[xxxvii]

It is estimated that at least 13 per cent of women in Canada have disabilities.[xxxviii] There are various types of disabilities, some permanent, some episodic. Fluctuations in mental wellness and substance use can be seen as disabilities themselves, and certainly are in various pieces of human rights legislation (see "2.5. Why should we reduce barriers to support?" page 30). For some women, experiences of violence may actually lead to disabilities (for example, brain injury or fluctua-tions in levels of mental wellness and/or substance use). Experiences with various forms of dis-crimination, including denial of or inaccessible services, may also affect women's levels of mental wellness and/or substance use.

Women with disabilities are more vulnerable to violence than women without disabilities because they may experience violence from a partner but also from family members or other people who act in a caregiving role.[xxxix] In addition, women with disabilities are more likely to live in poverty which can make it difficult for women to leave their abuser.[xl]

While many programs consider themselves accessible, often this refers only to wheelchair accessibility and women who may need visual aids or sign language interpreters may be overlooked when thinking about/planning for accessibility. Women with learning disabilities may find navigating systems, especially where paperwork is involved, frustrating and downright challenging. In addition, as Chappel notes, "program policies sometimes create unique barriers for certain women with disabilities, such as those who may not be able to be substance-free before entering treatment, who have a need for personal care or who may not be able to fully participate in strenuous group models".[xli]

Age

Both young women and elderly women face particular barriers that magnify other forms of marginalization. Both have limited economic and social power, and services are often not particularly appropriate for either age group.

– Minister's Advisory Council on Women's Health[xlii]

Older and younger women often face financial barriers that leave them more vulnerable to violence and make it more difficult to leave an abuser. Both groups are more likely to experience violence than the general population. As women grow older they become "increasingly vulnerable to violence from partners, other family members and caregivers."[xliii] Compared to younger women, they are more vulnerable to financial abuse.[xliv] Violence against older women is often classified as elder abuse, even though the dynamics may be the same as violence against younger women. Yet many agencies addressing elder abuse are unequipped to address violence against women, sometimes focusing on the financial abuse of men, and on women who are caregivers, as perpetrators.

Older women may be hesitant to report abuse if the abuser acts as a caregiver for fear of being placed in an institution. Women who are able to access support are sometimes put in unsafe positions by those whom they seek support from. For example, older women are prescribed more medications for mental wellness than any other age group. Specifically, older women are over-prescribed benzodiazepines, which can dull a woman's senses and affect her ability to assess her safety.[xlv] Finally, older women are less likely to access Violence Against Women (VAW) services than women in other age groups. When they do access support, Transitional Housing programs may not be able to accommodate older women's needs should they require additional assistance in their day-to-day activities.[xlvi]

Young women are also at a greater risk of experiencing violence than the general population. In fact, Canadian studies indicate that between 16 and 35 per cent of young women experience violence in relationships.[xlvii] Violence experienced by young women is not always taken seriously, but like violence against any women, can have negative effects. Young women who experience violence are more likely than young women who have not, to experience varying levels of mental wellness and/or substance use, and to experience violence later in life.[xlviii]

Economic Status

Many of the intersecting identities mentioned here have profound impacts on women's economic status. One in five women in Canada lives in poverty.[xlix] On average, women earn 62 percent of what men earn, with female lone-parents, Immigrant women and women of colour, including Aboriginal women, most affected by poverty.[l] Economic status, in turn, affects levels of mental wellness and substance use.[li] Poverty can impact a woman's ability to find safe, affordable housing, and to leave an abuser.

The services available to women with varying levels of mental wellness and/or substance use, vary with their economic status. Women who do not have access to financial resources or extended health care benefits are restricted to publicly funded programming and are unable to afford private treatment.[lii] Women who face income barriers (especially Aboriginal women) are more likely to have their children apprehended, which can further negatively impact levels of mental wellness and/or substance use.[liii]

Ethnicity and Culture

A woman's ethnicity or culture can play an important role in her experiences of violence, but also in her day-to-day interactions with people and systems in our society. For example, Aboriginal women in Canada are almost seven times more likely to be killed through

violence and are more likely to experience violence from a stranger than are non-Aboriginal women.[liv] Ongoing experiences of colonialism, including the lasting impacts of residential schools, may be contributing to higher rates of violence against Aboriginal women. Amnesty International has released a report on the marginalization of Indigenous women in Canada as a result of racist, or at the least, unhelpful policies, which often leave Aboriginal women vulnerable to violence and in poverty, with little resources or support.[lv]

Systemic racism and patriarchy have marginalized Aboriginal women and led to intersecting issues at the root of the multiple forms of violence. The result of the system of Colonization is a climate where Aboriginal women are particularly vulnerable to violence, victimization, and indifference by the state and society to their experiences of violence.

– Native Women's Associa-tion of Canada[lvi]

Women of colour may also be impacted in various ways by the lasting effects of colonialism and persistent racism. Jill Cory and Linda Dechief have noted that women of colour may be apprehensive to seek support for various reasons, including fears of encouraging stereotypes about the inherent violent nature of certain cultures, and of losing their children to social services.[lvii] In other cases, women may not report violence because they are worried about how their partner will be treated by police who hold racialized stereotypes about men of colour.

Racism not only feeds popular stereotypes about communities of colour as being more violent, but it also informs social policy and police practices so that these communities are under constant surveillance and men within these communities are criminalized. For communities to be labeled as violent leads to a situation where on the one hand, the women are dismissed as the violence they experience is normalized or culturalized, and the men on the other hand, are subjected to intense scrutiny and more likely to be subjected to punitive measures....Not only are [women] threatened with deportation by their abusive partners, but the State also threatens to deport both themselves and their partners. These dynamics also make communities of colour more cautious about disclosures of violence, and contribute to the stigmatization and exclusion of women who "tell."

– Yasmin Jiwani [lviii]

Immigrant and refugee status, or having no status in Canada at all, can also put women at greater risk of violence and pose significant barriers to support. Canadian immigration laws and regulations can be harmful to women who have been sponsored by a partner or family member and who are experiencing violence. Certain stipulations make it almost impossible for women who have been sponsored to access social assistance, social housing or job training programs, leaving women reliant on their sponsor to meet their "essential needs." For example, a woman's sponsor is required to repay any social assistance she takes on within ten years of immigrating to Canada. If a woman who has not yet obtained permanent-resident status

leaves a sponsor who is abusing her, she may be deported.[lix] In addition, Canada's domestic worker program requires women from outside of Canada who are hired to work in homes here, to live with their employers, which puts women at risk of exploitation and violence.[lx] Aside from these challenges, accessing information and support around experiences of violence, mental wellness and/or substance use can be challenging for women whose first language is not English.

Immigrant and Refugee women… experience isolation associated with loss of their support networks, language limitations, and cultural differences; poverty and labour market marginalization; and lack of access to services because of lack of information, social isolation, and inabil-ity to communicate in English".

– Justice Institute of BC[lxi]

Support services do not always reflect or create space for the various cultures of the women in BC, and as such, women may be hesitant or simply unaware of how to access supports. Women of colour and especially Aboriginal women may also decide against reaching out due to well founded fears that their children will be apprehended. There are more Aboriginal children in state care now than ever, including during the tenure of residential schools.[lxii] In general, violence, mental wellness and substance use are highly stigmatized in many cultures; talking about these issues may bring shame, not only to the women but to their family, which can prevent women from seeking support.

Geography

In rural communities … women with concurrent issues face additional barriers to service because of isolation, poverty, the lack of transportation, the lack of affordable housing and childcare, limited services for Aboriginal people, and a general lack of women -specific services.

– Collen Purdon, Grey Bruce Violence Prevention Coordinating Committee[lxiii]

In a nation-wide study exploring the challenges faced by people living in Canada's rural and re-mote areas, access to services was identified as the greatest problem.[lxiv] Barriers to service may exist due to a general lack of services in the area and because of high transportation costs to areas where services do exist. For example, the BCSTH 24-hour census of Violence Against Women (VAW) agencies within the BCSTH membership in 2009, identified transportation and childcare as significant barriers to service in all programs—especially in rural areas. Members also identified the need for more outreach resources to women in rural and remote areas. Women seeking support who have access to vehicles may experience challenging road condi-tions, especially in winter months, impeding a long drive to a service agency. Women who do not have access to vehicles may struggle to come up with taxi fare (where taxis are available); public transportation is often non-existent. Many agencies cannot afford, or do not offer, child-care services, making it difficult for women with children to access services.

Anonymity and confidentiality are always concerns for women fleeing violence but can become even greater challenges in small, rural communities. Community residents may

recognize the vehicle a woman drives, or relatives may work in the agency she is seeking support from. In some cases, people may not believe reports of violence or may not want to get involved when they know the people who are accused. On the other hand, women living in remote areas may not have family, friends or other support networks in the community they live in.[lxv] This geographic and social isolation can compound the isolation that is often part of the dynamic of violence against women.

In her research on VAW services in northern BC, Amanda Alexander found that women in rural and remote areas may be isolated from the workforce as well. She attributes this "to the work in single industry towns being predominately male dominated, with jobs available such as mining, heavy equipment operation and construction."[lxvi] Consequently, women may be physically relegated to their homes, socially isolated and financially dependent on their partners. In general, poverty may impact people living in rural communities more so than in urban areas because of their dependence on single-industry economies.[lxvii]

Gender Identity and Sexual Orientation

Although people who identify as lesbian, bisexual, queer and trans (LBQT) may experience the same forms of violence as heterosexual women, they may also experience unique forms of abuse. For instance, LBQT people may be threatened with being "outed," which could have negative ramifications for their families, occupations, child custody or for their children gener-ally. In addition, mainstream media fail to provide positive examples of same-sex relationships, leaving women to figure out for themselves whether what they are experiencing in their relationships is "normal." Brown argues that these factors combine to "render particular forms of violence, such as those experienced in lesbian, gay, bisexual, and trans communities, incoherent and invisible, so much so that some [people cannot] conceptualize their… partner's behaviour as abusive because of their oppressed status."[lxviii]

Gendered analyses of violence against women may or may not be applicable when we consider that some people may not identify themselves within the typical male and female gender framework. Aside from violence from partners due to the pervasiveness of sexism, homophobia and transphobia (and other types of discrimination). LBQT women may also experience vio-lence at the hands of their family, peers and strangers.[lxix] Yet LBQT women who experience violence may be hesitant to report such abuse because of the homophobia and transphobia present in police forces and social services, which could negatively impact themselves or their partners. This may be especially so in more rural or remote areas where service options are more limited. It is no surprise then, that LBQT women are significantly more likely to report anxiety, depression and thoughts or attempts at suicide than the general population.[lxx]

Stereotypes of transgender people attacking women come from movies and television shows that inaccurately portray transgender people as dangerous and abusive. This is far from the truth. When it comes to transgender people, the more serious risk is that violence will be committed against transgender people by others. Also, shelters need to learn that it is a myth that woman-only space is always safe. The

occurrence of woman-to-woman abuse by both straight and lesbian women is real, and shelters need clear rules against it. By enforcing these rules for all residents, transgender and non-transgender, these spaces can become truly safe.

– National Gay and Lesbian Task Force[lxxi]

Trans women in particular may experience significant barriers to residential services, facing policies, procedures and practices that are sometimes outright discriminatory. The 519 Com-munity Centre in Toronto and SHARP Access Project in Vancouver have noted that women who are trans often have to be post-operative, be able to ”pass” as a woman and have their legal identification reflect their ”female” status, all of which require significant financial resources to accomplish. Even after meeting these requirements, trans women may be secluded and forced to use men's washrooms. Mottett and Ohle, advocates with the National Gay and Lesbian Task Force in the United States, suggest that residences start with a policy of respect that includes treating people according to the gender they identify with, or acknowledging that people “are who they say they are.”[lxxii]

Pregnancy and Mothering

While pregnant and mothering women who experience violence are often viewed sympatheti-cally, predominant messages around mothering have lead women whose mental wellness and/or substance use is impacted by violence, to be labelled as abusers themselves.[lxxiii] Service providers working with mothers and pregnant women tend to focus on the child or fetus, at the expense of the woman and the context she lives in.[lxxiv] Substance use especially is seen as a choice, and the contexts that lead to substance use (such as violence and poverty) are often overlooked. Women with varying levels of mental wellness and/or substance use are frequently perceived as “bad mothers” even though they may treat their children well. Consequently, women who are mothers may be hesitant to seek support for violence, mental wellness and/or substance use for fear of having their children apprehended by child protection services.

Pregnant women/women who are mothers seeking support for mental wellness and, especially, substance use, find few resources available specific to their needs.[lxxv] Programs specific to women with children are often only available to women with very young children (for example, under two years of age), and residential programs rarely accommodate children at all. Women experiencing violence are likely unwilling to leave their children with an abuser, in order to ad-dress their own mental wellness and/or substance use. Even in the Violence Against Women (VAW) sector, service providers have identified a need for increased child care resources so that women are able to access support services while knowing their children are in a safe environment.

Sex Work

Sex work is a contentious issue in feminist communities, but there is one thing we can all agree on—the safety of women who do sex work is as important as the safety of all women, but is often overlooked by our society.

The stigma surrounding sex work in Canada marginalizes women who do sex work, and according to the World Health Organization, contributes to higher rates of violence for

women who work on the streets compared to the general population.[lxxvi] Due to the current legal system, it is difficult for women to work indoors—where, research shows, they are able to take more time to negotiate and assess their safety.[lxxvii] Women who do sex work may be unaware that they are able to access Violence Against Women (VAW) services after experiencing violence on the job. When they do seek support, women may experience negative judgment from those who are in a position to respond.

Sex workers are unlikely to report violence they experience to authorities due to the quasi-criminal status of the work they do, and because of feelings that their complaints are not always taken seriously and followed up.[lxxviii] In some cases, women may face more violence from the police officers they try to file a report with. Sex workers may also face discrimination when attempting to access Transition Housing programs, as some programs have rules (such as curfews) which make it difficult for women to work without being asked to leave. As a result, women may lie about their occupation and miss out on opportunities to develop safety plans suited to their work.

Some women experience sex work (especially at street-level) as a means of survival. For women who see sex work as a means of survival, mental wellness, substance use and sex work may be experienced as mutually reinforcing, which can make it difficult to reduce levels should a woman make that choice. Other women choose sex work (as they would any other occupation), where they earn a sustainable income in a short amount of time. Regardless of the motivations behind sex work, it is essential that Transition Housing program staff respect women's autonomy and, with a women-centred, harm-reduction approach, focus only on those issues that a woman indicates she wants support around.

Spirituality

Spirituality can mean different things to different people, and may or may not be related to one's culture. For some, spirituality may be related to an established religion. For others, it may involve a feeling of connection to other living things around us. Some talk about being in tune with our physical, mental and spiritual bodies. Some women identify spirituality as an integral part of their identity, and research shows that spirituality may be a resource that can help women cope with and work through experiences of violence, mental wellness and/or substance use.[lxxix]

Christianity is still seen as the norm in BC and programs are often structured around this norm. Some substance use programs include or make reference to a Christian God, and simply adding other deities to the existing prayer may not make sense for all women. Programs may celebrate Christian holidays (such as Christmas or Easter) but fail to create space for observances that are important to women who practice other religions or faiths. Even food can create discomfort for women whose religious or spiritual beliefs entail specific dietary practices and requirements.

Staff may also hold harmful views or believe harmful stereotypes about specific religions that could impact their work to support women. It is important not to make assumptions about women's spirituality, or about the role spirituality plays in women's lives. Spirituality and spiritual communities or connections may help women in times of crisis, but may also further contribute to their experiences of abuse. It is up to each program to create space for women to practice and

explore their spirituality, and the role it may play in her experiences of violence, mental wellness and/or substance use.

2.4. Barriers to Providing Service

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

– Patricia Bland and Debi Edmund[lxxx]

Reflective Questions

What gets in the way of providing services and support to women with varying levels of mental wellness and/or substance use? What are some ways you have found to work around, or through, those challenges? How can you build on those efforts?

Misinformation and lack of training around supporting women with varying levels of mental wellness and/or substance use can create barriers to providing service, by leading service providers to believe harmful stereotypes and to consequently deny women service. Some staff worry about the safety of other women, and especially children, residing in the Transition Housing program if women with varying levels of mental wellness and/or substance use enter the house. But as BC researchers and advocates have noted:

It is helpful for service providers to recognize that people can experience varying levels of severity of substance use and substance use problems, and that one's substance use, even if it is situationally intense, does not necessarily mean that it will lead to behaviour or substance use that is "out of control."
– BC Centre of Excellence for Women's Health[lxxxi]

These researchers remind us that mental wellness and substance use exist on a continuum and that the levels themselves do not necessarily lead to behaviours that are harmful to others.

Other concerns that Transition Housing program staff have, centre around "triggering" other women in the house who may themselves have (or have had) varying levels of mental wellness, or who are abstaining from substance use. Some people argue that the focus needs to shift from attempting to ensure there are no triggers in a Transitional Housing program (in other words, denying some women service based on their mental wellness and/or substance use), to strategizing with women around how best to deal with triggers when they come up, an approach that may be more beneficial in the long run.

Aside from misinformation about women with varying levels of mental wellness and/or substance use, staff in Transition Housing programs may experience a number of other challenges to supporting women. Limited resources can create barriers to providing service to some women fleeing violence. For example, generally speaking, anti-violence workers earn less than other support sectors; low pay can lead to high levels of staff turnover, which impacts the quality of services women fleeing violence receive. Finding and

recruiting qualified staff who are proficient in the dynamics of violence against women may be difficult for any agency, but this is especially so for rural and remote service agencies. Many Transition Housing programs are unable to afford to pay for "double-staffing," where two staff members are on-site at a time to support women, youth and children. With only one staff member available, front-line workers can be overwhelmed when extra support is required.

Geography can also have a significant impact on the ability of service providers to support women fleeing violence. Service providers often have official "catchment areas" from which the women they support are supposed to come from. When met with a woman from outside these areas, service agencies either have to refer her to another agency or bend the rules by taking her in. This dilemma can be especially challenging for service providers in rural and remote areas that are often isolated, with little or no support themselves and few choices when it comes to referring women to other agencies. Because of this, some service providers see and support clients that are not typically within their mandate. However, this extra work is not often reflected in official reports due to fear of a backlash from funders. Working long hours and having to take on many roles can lead providers to feel "burnout," and negatively impact the service women receive.

Some programs have found that teaming up for cross-training, developing working partnerships or even co-facilitating groups with mental wellness and/or substance use service providers can help improve confidence among front line workers. It may also help reduce the "chaotic" feeling that many service providers relate, when supporting women fleeing violence who may or may not have varying levels of mental wellness and/or substance use. Working together also helps decrease the sense of isolation many workers feel.

2.5. Why Should We Reduce Barriers to Support?

If we choose not to work with [women with varying levels of mental wellness and substance use], we are declaring them as unworthy recipients of our services. We may feel scared by our lack of experience or knowledge about working with [this population of] women. Yet this fear can deny women the right to live free from violence.

– Stella Project[lxxxii]

Despite the many challenges service providers experience, it is our responsibility to do the best we can with what we have, to support women fleeing violence. When women access Transitional Housing programs we work with them to decrease their risk of experiencing violence at the hands of their abuser, but we can provide other tools and information to reduce harm and increase women's safety as well. Rather than screening some women out of our services with the intention of keeping other women, youth and children safe from them, we need to find ways of keeping women safe no matter what their levels of mental wellness and/or substance use are. Establishing authentic, trusting relationships will create space for open conversations about violence against women and enhance the safety of the women we support.

Women who feel as though they may lose access to a Transition Housing program—if they

speak about their levels of mental wellness and/or substance use—are not able to fully account for, and speak to, the impacts of violence against women. Nor are you able to talk about and create realistic plans for greater safety, together with the women. Women who can talk openly without fear or negative repercussions can better plan to improve their safety from an abuser while experiencing symptoms or responses related to mental wellness and/or substance use. But planning for safety from violence is just one aspect of a realistic safety plan. For example, Transition Housing programs can offer informational resources and groups for women that help women recognize and manage symptoms related to mental wellness, as well as cover safer substance use practices—whether that means switching to another substance, finding ways to use a substance in a safer way, or cutting down on/stopping substance use all together. Partnering with other agencies in your community (if they exist) can aid this process.

Aside from the desire to keep all women safe, existing provincial, federal and international legislation requires us to provide services to women regardless of their health status, including mental wellness and/or substance use. In BC, Chapter 210, Section 8 of the BC Human Rights Code reads:

8 (1) A person must not, without a bona fide deny to a person or class of persons

a. any accommodation, service or facility customarily available to the public, or
b. discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public

because of the race, colour, ancestry, place of ori-gin, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or class of persons.[lxxxiii]

In addition to this provincial legislation, the Canadian Human Rights Act makes it illegal for service providers to discriminate against any one group of people, including people with “physical or mental disability.” “Disability,” in the Act, is defined as either:

- physical or mental;
- previous or existing, and
- including dependence on alcohol or a drug.[lxxxiv]

The Act goes on to require service providers to “accommodate special needs short of undue hardship,” which the court has developed a test to assess.[lxxxv]

The United Nations (UN) Universal Declaration of Human Rights, which Canada helped create, states:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[lxxxvi]

In 2008 the UN adopted the Convention on the Rights of Persons with Disabilities, which broadly defines disability and acknowledges that “discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of human persons.”[lxxxvii] Although mental wellness and/or substance use are not always thought of as disabilities, this language and framework may

create space to see them as health impacts of violence, just as physical injuries are. It also encourages us to set boundaries around behaviours, rather than focussing on women's levels of mental wellness and/or substance alone as criteria for admission/continuing on in a Transition Housing program.

There are compelling moral and legal reasons for reducing barriers to support for women with varying levels of mental wellness and/or substance use who are fleeing violence. We hope you and others in your program will think of these and other reasons, reflect on what gets in the way of sheltering some women, and how you may work through or around those challenges to ensure all women who are fleeing violence are able to get the support they need. In the next section, we outline some of the Promising Principles that may help guide you as you and others in your program move forward to do this.

Responses to Reflective Questions on page 17

Aside from mental wellness and/or substance use, what might lead to, or explain, the following behaviours?

Nodding off

- Has not slept in days for fear of her life.
- May be the first time in days/weeks the woman has felt comfortable enough to sleep.
- Physical illness (such as sleep apnea, concussion).

Incoherence

- Lack of sleep for fear of violence.
- Hearing impairments that could have resulted from violence.
- Speech impediments that could have resulted from violence.
- Head injuries/concussions sustained from violence.
- Physical illness (such as fever, diabetes, stroke).

Swearing

- We each have our own vocabulary based on our social context—what is deemed a "bad" word by some women may be a part of every day, acceptable language for others.
- May not feel she is being treated in a fair or respectful way.

Anger or rage reactions

- Normal responses to violence.
- May also be normal ways of interacting in her relationships.
- May be the only way she has been able to leverage her abuser in the past.
- May feel she is not being treated fairly or in a respectful way.
- Sign of frustration.
- May be the first time she has been able to express these emotions in a way where she isn't judged, or isn't afraid of reprisals.

For Further Reading

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SECTION 3

Promising Principles

Reducing Barriers to Support for Women Fleeing Violence

A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use

Section 3 Table of Contents

Section 3 Summary

Promising Principles

Women-Centred

- Treat women as the experts of their own lives.
- Provide non-judgmental information.
- Support women in the decisions they make.

Anti-Oppression

- Be aware of the various forms of discrimination, oppression or stress that women may be experiencing.
- Act in ways that do not contribute to feelings of oppression.

Relational Approaches

- Focus on building relationships based on respect and trust.
- Model relationships that counter the controlling and coercive characteristics of abusive relationships.

Harm Reduction

- Situate women's behaviours in the context of their lived experiences.
- Provide realistic options and services to women.
- Focus on reducing harms now (such as keeping women safer) while working to help them achieve their longer term goals.
- Think about how our policies and procedures may also be causing women harm, and work to reduce those harms.

Holistic and Integrated Services

- Create space for women to explore and discuss the connections between violence, mental wellness and/or substance use.
- Collaborate and coordinate with other service providers to better support women.

Flexibility

- Every woman we support is different and has unique needs and goals.
- Every program operates in a unique context (geography, funding, resources).
- Flexibility is important to meet the varying needs of women.
- Consistency and transparency is also important so that policies, procedures and guidelines do not feel arbitrary.

Section 3 Reflective Questions

1. The term "women-centred" may be used in your agency, but what does it mean? Definitions and ideas about women-centred practices vary. Take some time and think about what women-centred means to you and talk to other people in your agency to find out what it means to them.
   In what ways are your services currently women-centred? Where is there room for change to build on your current policies, procedures and practices?
2. Using the five criteria of systemic oppression (see Section 3, page 11), think about how the policies, procedures and practices around mental wellness and/or substance use in your program may have been developed.
3. Think about your own ethnicity or culture. Is everyone who shares your cultural background exactly like you? What similarities do you share? What are some of the differences?
   How do we ensure that we are not working in ways that further oppress the women we are supporting?
4. What are some of the ways experiences in Transition Housing programs may echo the violence a woman experiences from her partner?
   What are some things Transition Housing program staff can do to counter the violence women experience and to ensure women are in a safe space?
5. How are you currently working to build and model respectful, mutual relationships in your work? How can you build on this?
6. In what ways are you already encouraging or engaging in harm reduction with the women you work with?
   How can you build on these efforts? Think about this in terms of violence, mental wellness and/or substance use.
7. Are you aware of what services are available in your community around violence, mental wellness and/or substance use?
   What do you know about the services they provide? Use the chart provided in the Appendix to create a resource list of programs in your community.
   How can you improve your relationship with these service providers and plan to collaborate to better serve women?
8. Do you feel your services are flexible or adaptable enough to meet the varying needs of the women who access your program? How so, or how not? What gets in the way of being flexible? How can we be more responsive to the varying needs of women fleeing violence?

The shift towards reducing barriers for women fleeing violence who have varying levels of mental wellness and/or substance use requires re-thinking how we serve all women fleeing violence.

– BC Society of Transition Houses

There are various practices, tools and programs for supporting women at risk of violence who have varying levels of mental wellness and/or substance use. Practices vary with the context of the women we are working with, as well as the context we are working in—for example, the geographical location, cultural composition and level of resources available in our community. Still, women, anti-violence advocates and researchers have identified a core set of philosophies or principles that are essential for supporting women who have experienced violence. These principles are the foundation from which your programs, and you as a worker, will support women.

For some organizations, the philosophies outlined in this section and reflected in the Promising Practices may be quite different from the frameworks and philosophies currently in use. When working to implement the Promising Practices it is important to have discussions about these values, to think about how they align with what is in this toolkit, and plan for how to work through the feelings that arise when they are not. The shift to these philosophies will not happen overnight. It requires commitment from all levels of the organization to create space for conversations about the benefits of moving in these directions, about hesitancies and challenges in doing so and about how to support one another in overcoming them.

3.1. Women-Centred

Women-Centred Care is based on the assumption that women know their own reality best ... – Jill Cory[i]

While most anti-violence service providers identify their services as women-centred, this concept is rarely defined and practices vary from agency to agency. Generally, women-centred services refer to practices where service providers:

- treat women as experts of their own lives and take the lead from the women they are supporting
- focus on women's strengths and accomplishments (strengths-based approach)
- provide non-judgemental information about the various options available to women, and respect and support their decisions
- acknowledge the social realities and various inequities/forms of oppression that impact women, rather than focussing on individual characteristics or choices
- actively work to reduce women's barriers to accessing support, stemming from women's social contexts and experiences with oppression
- honour diversity by being respectful and reflective of each woman's cultural and social context
- recognize the various identities that women claim, and avoid focussing on only one aspect of her identity.

In a women-centred framework we think about, and account for, the various social factors and contexts that shape women's lives. Women hold various social identities and live in various contexts. These are unique to each woman, and in turn, make each woman

unique. Because each woman is unique, our services must be flexible and directed by the individual woman we are working with.

In the Northwest Territories, anti-violence advocates have identified the key elements of women-centred care as:

1. Partnership and collaboration.
2. Respect.
3. Empowerment.
4. Complete support of all decisions—while also openly discussing potential results for each decision.
5. Striving to understand women's needs from their perspective.
6. Truly believing women are "the experts" about their own circumstances and possible solutions.
7. Recognizing the impact of women's social environment on their current and past behavior—while also helping them recognize this impact.
8. Recognition and discussion of the oppression women experience, and their experience of "simply" being women.
9. Recognizing and helping women discover their strength, resources and resistance to all forms of oppression, including violence.
10. Paying attention to the practical things needed by women (such as childcare and transportation) to ease their access to services.[ii]

Some misconceptions about women-centred services include practices where service providers:

- attempt to identify what is in the best interest of the women, without working with the individual to determine what she needs/wants
- provide information only about the course(s) of action we think is/are best for the women, rather than exploring all options with the individual
- focus solely on women's individual choices rather than considering the many social contexts and factors that impact women's lives
- recommend certain courses of action that are not a good fit for women, or that do not take into account their social context (such as culture, geographic location, age, ability)
- see ourselves as experts/authorities rather than seeing women as experts of their own lives
- apply a women-centred framework when working with some women, and not others (such as deeming some women as competent to make decisions for themselves, and not others)

For more tips about women-centred practices see Helping Abused Women in Shelters: 101 Things to Know, Say and Do available in the BCSTH library.[iii]

Reflective Questions

The term "women-centred" may be used in your agency, but what does it mean? Definitions and ideas about women-centred practices vary. Take some time and think about what women-centred means to you, and talk to other people in your agency to find out what it means to them.

In what ways are your services currently women-centred? Where is there room for change to build on your current policies, procedures and practices?

3.2. Anti-Oppression

The term oppression is generally used to refer to the act of holding a group or individual in a subordinate (or inferior) position by using force, authority, or societal norms (things that the majority of people in society consider to be good, right and 'normal').

– Northwest Territories Health and Social Services[iv]

An anti-oppression framework is essential to providing women-centred service. To best understand how violence, mental wellness and substance use impact women, the social context in which a woman lives must be taken into consideration. The various points of oppression that exist in our society, and that she may experience, must be taken into account. Levels of mental wellness and/or substance use may fluctuate as women cope with violence they experience, but also with other social inequities—including homelessness, poverty and discrimination based on a woman's ability, Aboriginality, experiences of colonization, citizenship/nationality, class, education, ethnicity, gender, geographic location, health, occupation, refugee/immigrant status, religion, sexuality and sex (this list is not exhaustive).

Based on their social contexts, women may experience various forms of discrimination and oppression from the systems and people in our society. It is important for us to reflect on these various contexts and the societal beliefs often associated with them, to ensure we are not contributing to discrimination or oppressive experiences of women. To some extent we are all impacted by, and internalize, various forms of discrimination (such as racism, ableism, heterosexism). Thinking about how this is so, enables us to strategize and consciously act in ways that counter oppressive experiences for women, and move towards building relationships built on mutual respect—where women are valued. Thinking of the broader social context a woman lives in also encourages us to remember that levels of mental wellness and/or substance use are just two aspects of women's lives, and may or may not be central in women's experiences. It is up to us to learn about the pressures or stressors women experience, and to work to support women as they navigate them.

In their family violence shelter training, the Northwest Territories Health and Social Services point out that all Transition Housing staff hold power over the women they serve and must work to even out those power differences. They show us how seemingly innocent rules may actually be a form of systemic oppression, because they are often developed without much thought about, or value given to, various cultures and ways of being. They see systemic oppression happening when there is:

- belief that one's own cultural practices are better and more desirable than others' (such as, if staff believes washing the dishes is best done right after eating)
- belief that other cultural practices are not as good as one's own (such as, if staff believes not washing dishes right after eating is a sign of laziness)
- power to influence others and impose beliefs on other people (such as, if staff persuades other staff and managers about need to make sure women are cleaning their dishes directly after eating)
- appearance of "better and more desirable" cultural practices in organizations, laws, programs and policies (such as: formally—directive to wash dishes directly after eating is put into house rules

and will result in a formal warning if not followed; informally—women who do not wash their dishes directly after eating are seen as lazy)
- invisibility of these "better" cultural practices, which allows them to be subtle and hidden because they are not questioned (such as, assuming dishwashing directly after eating is "just the way it is," and is the best way to do things without questioning why, or if, the rule is necessary)

The dishwashing example we chose to use is less obvious as a possible form of oppression, but the five criteria for systemic oppression above are also clearly visible in rules that restrict access to services for women fleeing violence.

Reflective Questions

Using the five criteria above, think about how the policies, procedures and practices around mental wellness and/or substance use in your program may have been developed.

[The] fear of offending someone or of not knowing all there is to know about a certain culture or group has resulted in the use of blanket approaches by many organizations and professionals. A blanket approach treats everyone who is accessing the service the same. While this approach has good intentions, what it really does is ignore important differences between the different people and their cultures and experiences. Ignoring these differences is really evading or tiptoeing around issues related to power and it promotes the idea that we are all the same in terms of our worldviews and how we interpret the meaning of things.

– Northwest Territories Health and Social Services[v]

Reflective Questions

Think about your own ethnicity or culture. Is everyone who shares your cultural background exactly like you? What similarities do you share? What are some of the differences? How do we ensure that we are not working in ways that further oppress the women we are supporting?

In their discussion of trauma, mental health and substance use within an anti-oppression context, anti-violence advocates in BC have outlined these key elements for working with women who have experienced violence, and who have varying levels of mental wellness and/or substance use:

- Come from a foundation of honest self-reflection.
- Ask value-neutral questions and listen to the answers.
- Examine and resist societal beliefs about mental health and/or substance use; understand oppressions such as racism, sexism, ableism, poverty, homophobia, transphobia, colonization and how they relate to beliefs about mental health and/or substance use.
- Maintain an attitude of engaged neutrality when providing services.
- Focus on behaviours and context, as opposed to labels and diagnoses.[vi]

The Transition Housing environment can echo abusive characteristics that women are wishing to get away from. This can include abusive characteristics in relationships between staff; relationships between staff and residents;

and relationships between residents. As it is our goal to provide women with a safe place, it is our responsibility to create time and space for reflection on these relationships and the culture of the programs and agencies we work in, to ensure they are built on respect and autonomy. As power and control are heralded features we are taught to aspire towards in our society, Transition Housing program staff are tasked with working in ways that are not usually encouraged in other workplaces, or in larger society in general.

See the Sample Staff Guidelines and *Transition House Worker Declaration*[vii] in the Appendix (page 23) that Transition Housing program managers and staff can discuss, and sign, to pledge ongoing commitment to anti-oppressive practices.

Reflective Questions

What are some of the ways experiences in Transition Housing programs may echo the violence a woman experiences from her partner? See the *Abusive Power and Control within the Domestic Violence Shelter wheel* in the Appendix (page 25) for some ideas.[viii]

What are some things Transition Housing program staff can do to counter the violence women experience, and to ensure women are in a safe space? See the *Advocacy Empowerment wheel* in the Appendix (page 26) for ideas.[ix]

See the Ontario Association of Internal and Transition Houses' *A Guide to Critical Reflection*: Understanding and Using a Feminist Anti-Oppression Framework to learn more about working from an anti-oppression perspective.
www.oaith.ca/assets/files/Training/ARAO_Manual.pdf

3.3. Relational Approaches

When women are asked about the kind of approaches that have been the most effective for them, a supportive, non-stigmatizing relationship with a service provider is among the most helpful and effective. On the other hand, one of the main barriers to seeking help and support is the fear of being treated prejudicially.

– Margaret Leslie and Gary Roberts[x]

Relationships Between Workers and Residents

In consultations with women for the Reducing Barriers project, a key consideration was the feeling that they had a caring and respectful relationship with the service provider. What services were provided, or which sector women accessed support from, was considered less important. As other researchers have found, the women said "the support of a caring, respectful, accepting, patient, encouraging, inspiring, and empathetic service provider is pivotal…."[xi] However this is sometimes easier said than done, and building a trusting relationship takes time—something that Transition Housing programs (and especially Safe Homes) often have little of. But support workers can make the most of the time they have with women, focusing on building a trusting relationship from the first point of contact. As one advocate says, staff can "model 'healthy,' 'mutual' relationships by paying close attention to issues of power and hierarchy within the…relationship and by being open, honest, trustworthy and encouraging."[xii]

See the Alaska Network on Domestic Violence and Sexual Assault's Trust Isn't Always Easy in the Appendix for more on building a trusting relationship with the woman you work with.

Our attitude will usually determine a woman's reaction. If she perceives us to be fair and open it is more likely she will be open.

– Northwest Territories Health and Social Services[xiii]

Relationships Between Residents

Although the communal living that is a part of Transition Housing programs can have many drawbacks, it presents an opportunity for women to talk with other women about their experiences of violence, mental wellness and/or substance use. These kinds of connections can help women to feel less isolated and give women the opportunity to support one another around the effects of violence. Women in the Reducing Barriers focus groups spoke of the need for services to create space for women to connect with one another through formal groups or informal drop ins. In the mental wellness context, women have described the benefits of peer support with providing a "trusting, safe and accepting environment…where people [can] 'talk openly,, 'feel validated' and 'share stories,' exchange information and learn from each other."[xiv]

Chrysalis Society, a program for women who use substances in Vancouver, have developed a sistering program where women who have moved through the program volunteer to mentor and support women who are new to the program and who are transitioning on.

Reflective Questions

How are you currently working to build and model respectful, mutual relationships in your work? How can you build on this?

3.4. Harm Reduction

Harm reduction is a philosophy initially developed and adopted by people organizing around HIV/AIDS crisis and other health issues among injection drug users, but its impact and implication for the rest of the progressive social change movement is far-reaching. – Emi Koyama[xv]

There are many definitions of harm reduction. The BC Harm Reduction Strategies and Services branch describe harm reduction as:

...taking action through policy and programming to reduce the harmful effects of behaviour. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills, resources and supports for individuals, their families and communities, to make informed decisions to be safer and healthier.[xvi]

Harm reduction, as a philosophy:

- Accepts that behaviours that may be harmful are, to some extent, inevitable in society.
- Emphasizes the larger array of problems associated with behaviours, including those that contribute to the behaviours in the first place.
- Emphasize quality of individual and community life in policies and practices, and not necessarily completely stopping behaviours that may be harmful.
- Focusses on reducing harmful effects of behaviours in a way that supports personal choice, individual strengths and the motivation to change, without imposing moral judgements.
- Examines potential harms associated with behaviours, as well as with existing policies and practices.[xvii]

Although harm reduction is often associated with substance use, the applicability of the framework is much broader. For example, anti-violence and health advocates we consulted with pointed out that supplying food, housing and safety, and fostering trusting relationships, all serve to reduce harms to women. Anti-violence workers engage in harm reduction approaches when supporting women fleeing violence.

The Transition Housing movement itself was started as a form of harm reduction, designed to end violence against women while providing women and their children with a safe, supportive place to go until that goal was realized. Advocates provide non-judgemental support, offering information about the various options women have and working with women to identify and build on ways they have tried to stay safe, whether they chose to stay or leave their abuser. These conversations take place in an open, nonjudgmental atmosphere where women have access to information about violence against women and its impacts if they are interested, but are not pressured to engage in any services or to make any decisions they are not comfortable with. Women are welcomed back, should they need anti-violence services and support again. In doing this work, anti-violence advocates find nonjudgemental ways to help reduce the harms associated with violence.

While feminist activists and anti-violence workers provide information so that women can make informed decisions, they also acknowledge that women's health is not just a product of individual choice. Social factors—like experiences with violence, homelessness, poverty, criminalization and other forms of discrimination—impact women's health and lives, as well as their ability to access and engage with social supports. We acknowledge where women are at, and avoid pressing "women to make changes that are impossible for them [or] they will often perceive that we don't understand their circumstances or abilities."[xviii] The information and support we provide is realistic and reflective of the lives of the women we work with and support. This is not to say we can never see the end goal as stopping the behaviour altogether, or leaving the abuser; this may be a goal some women would like to reach, but it is up to each woman to define her current, desired or ultimate goal on her own terms, and in her own time. In this way, harm reduction is highly compatible with women-centred practices, as the philosophy encourages us to identify and measure success based on what the person we are working with is hoping to achieve.

Redefined in terms of survivor advocacy, harm reduction could mean a set of practical strategies that reduce negative consequences to survivors' lives through making available a larger pool of information and options, while honoring each survivor's own goals and coping strategies. This includes behaviors that have been traditionally labeled as "maladaptive," or "unhealthy," such as alcohol and drug use, self-hurting, sex work, irregular eating and sleeping, and staying in contact with the perpetrator—those behaviors that could get a woman evicted from domestic violence shelters today. – *Emi Koyama*[xix]

Reflective Questions

In what ways are you already encouraging or engaging in harm reduction with the women you work with?

How can you build on these efforts? Think about this in terms of violence, mental wellness and/or substance use.

3.5. Holistic and Integrated

Simply recognizing the connections between violence, mental wellness and/or substance use is a first step in providing relevant and respectful services to women fleeing violence. It is important that our programs create spaces where women are able to speak about the various ways violence has affected them. Despite evidence that violence, mental wellness and/or substance use are deeply connected, most services for women have not adapted to reflect the realities of the women they serve. This leaves women having to access many different services to get support around each need. Women are often unable to talk about how violence, mental wellness and/or substance use are connected for them, and because of philosophical differences in each service sector, the information they receive from one service provider can contradict the next.

Women benefit when service providers work together and integrate their services. Anti-violence, mental wellness and/or substance use sectors can collaborate to ensure their services are responsive to the varied needs of the women they serve. Collaboration can include approaching local agencies that do work around mental wellness and/or substance use to create either formal or informal partnerships. Partners can start with cross-training—for example, anti-violence agencies educating partners about the importance of gender and about violence informed practices; and mental wellness and/or substance use agencies educating their anti-violence partners about practical skills for supporting women with varying levels of mental wellness and/or substance use.

The Women, Co-Occurring Disorders and Violence study involved 14 different sites across the U.S.A. that tried innovative, integrated, violence-informed approaches to supporting women, developed in collaboration with women with lived experiences. Those involved with the study found that women who were involved in the new programs, reported showed more improvement in their levels of mental wellness and/or substance use compared to women who received support through traditional (non-integrated) means.[xx]

Collaboration may also mean informally or formally working with another agency to provide better services for women; in doing so, you'll need to make sure you're adhering to privacy laws and the information-sharing policies of your agency. One option is partnering with service providers from the mental wellness and/or substance use sector, to help women learn about the connections between violence, mental wellness and/or substance use. These kinds of discussions can also help women who are not impacted by mental wellness and/or substance use, to be more aware of the challenges some women face—and, as one advocate says, mitigate concerns that "more flexible admission and discharge policies for...women can have a negative impact on other shelter residents...."[xxi] Fully integrated services can vary from integration of policy, funding and programs, to having anti-violence, mental wellness and/or substance use service providers operate under one roof.

The Woman Abuse Response Program at BC Women's Hospital & Health Centre has developed a curriculum called "Making Connections" that involves facilitating groups for women to explore and talk about the connections between violence against women, mental wellness and/or substance use. The groups are co-facilitated by workers from the anti-violence and mental wellness sectors, and are complemented by a self-help guide for women.[xxii]

While it's important to view solutions to the lack of connection between the substance abuse and domestic violence service systems from a more global perspective, and to advocate for needed systemic reform, it's equally important to search for solutions in the here and now.

– *Theresa Zubretsky*[xxiii]

Reflective Questions

Are you aware of the services available in your community around violence, mental wellness and/or substance use?

What do you know about the services they provide? Use the chart provided in the Reducing Barriers Appendix (page 20) to create a resource list of programs in your community.

How can you improve your relationship with these service providers, and plan to collaborate to better serve women?

3.6. Flexibility

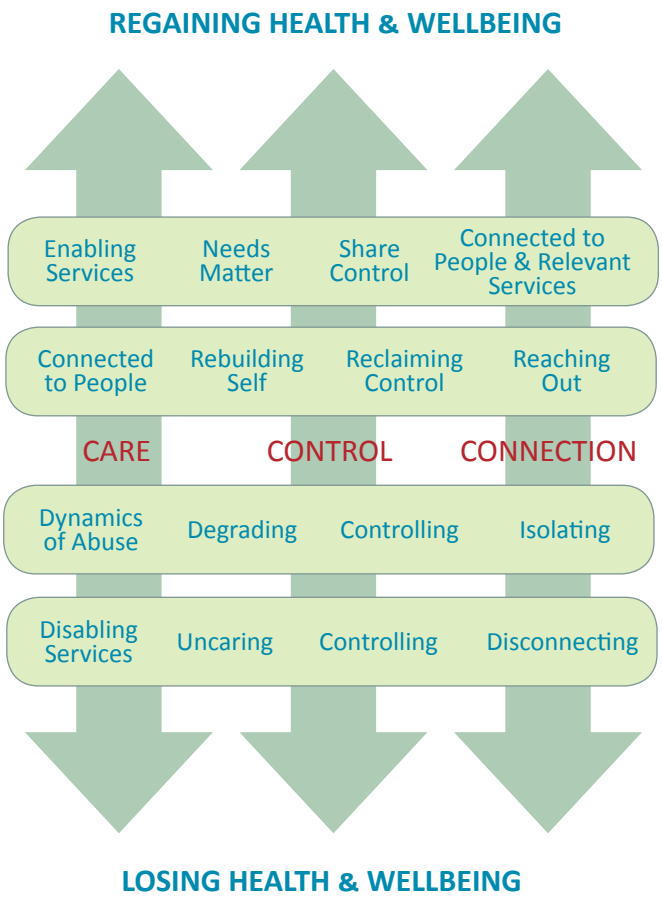
The work we do is complex. There is no "one size fits all" tool or checklist to "good" service, and no way to avoid the many challenges inherent to supporting women in Transition Housing programs. The work requires us to constantly think about and ask women how best we can support them. Each woman we encounter will be different in terms of where she is coming from, and what she needs and wants. Every program is unique, with varying levels of funding, staffing and other community services available. As a result we are constantly adapting how we work with women, and how we do the work—situated in our programs and in our communities. Service goals and service plans will change, and our programs will need to be adaptable to respond to the various needs of women.

Even with this flexibility, the core Promising Philosophies outlined in this section will always be the foundation on which respectful policies, procedures and practices are built. Programs should have clear program policies and procedures that ensure quality services, and although we need to be flexible, these standards need to be put into practice consistently across different shifts and staff. Our ultimate goal is to find ways to keep women in our programs, or find other programming the women feel is a good fit.

Reflective Questions

Do you feel your services are flexible or adaptable enough to meet the varying needs of the women who access your program? How so, or how not? What gets in the way of being flexible? How can we be more responsive to the varying needs of women fleeing violence?

Lynda Dechief heard women accessing health care who had experienced violence, advocate for health care workers to use similar Promising Philosophies to those outlined above.[xxiv] Dechief found that health care services ranged on a continuum that could either resemble the abuse women experience, or support women's attempts to regain control over their lives and health. Women said they want to feel cared for, to feel that they have control over their service experience and to feel connected to the service provider and larger community. We've adapted Dechief's model to show how anti-violence services can either help or further harm women's health and well being.



3.7. Conclusion

We have talked about the importance of women-centred, anti-oppressive, harm reduction, relational, holistic and integrated, and flexible services. These models are highly compatible; service is built around the needs each woman identifies, as opposed to trying to fit a woman into a pre-existing, rigid program. We know that these kinds of flexible, responsive approaches, where women are treated as the experts of their experiences, are more effective in terms of satisfaction and in terms of what women say they get out of the service. In Section 4 we provide some practical tips on how to apply these core philosophies in your daily work. As discussed above, we need to be flexible in how we "do" the work we do. We cannot provide you with any one right way of doing the work, but we have provided some ideas about how the Promising Philosophies can be applied in practice.

For Further Reading

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SECTION 3 - APPENDIX

Sample Principles in Staff Guidelines/Code of Conduct

Philosophies included in Helping Abused Women in Shelters:
101 Things to Know, Say and Do, include:

1. Respect confidentiality and a woman's right to privacy
2. Maintain appropriate boundaries
3. Model non-violence, non-abusiveness, tolerance and respect for others
4. Be aware of your own biases and do not impose them on others
5. Be conscious of distributing your time and attention to all women
6. Do not pathologize a woman and her coping strategies
7. Be aware of the power imbalance inherent in the helper/helped relationship
8. Take responsibility for self-care and monitoring your own emotional balance
9. Don't encourage a woman's dependence on you or on the Transition House program
10. Avoid conflicts of interest

Northwest Territories Health & Social Services. Supporting Northern Women: A Northwest Territories Family Violence Shelter Worker Training Program.

Shelter Worker Declaration

I, _____, declare that I will fulfill my responsibilities at [Program Name] to the best of my ability and in accordance with the following Code of Ethical Conduct:

RESPECT

1. I will strive to support the self-determination, dignity and self-worth of women using our services.
2. I will promote respect for the diversity of cultures in our community and society.
3. I will treat all residents, co-workers, other workers or any other persons with respect.
4. I will not practice or condone any form of discrimination against residents, staff or any other persons.
5. I am aware of the inherent power imbalance between staff and users of our services, and I will strive to minimize possible impacts from it.

SHELTER SERVICES

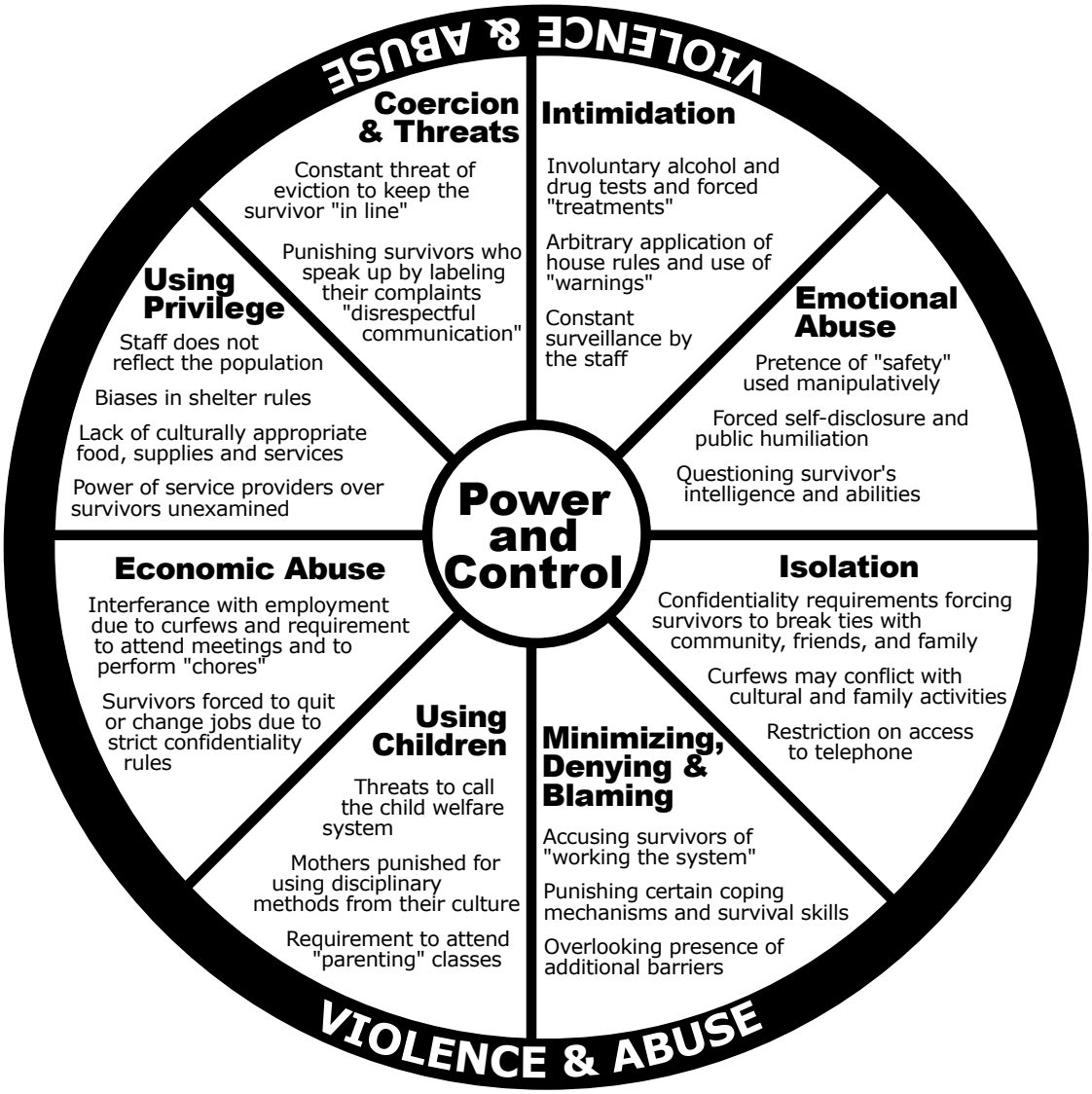
6. My primary responsibility is for the safety and well-being of the women and children using the services of the Transition Housing program.
7. I will work for the best interests of women and children using the Transition Housing program services.
8. I will strive to provide women with information they need so that they can make informed decisions.
9. I will ensure that women are aware of their rights to access our services and other services, and to provide informed consent.
10. I will respect confidentiality and the privacy of women using the Transition Housing program services other than when disclosure is required by law.
11. I will never disclose to any outside person the identity of women and children who have contacted the Transition Housing program or used our services, or the identity of my co-workers, unless required to do so by law.
12. I will respect the fact that my work site is also someone's temporary home.
13. I will work to fulfill the mission and values of our organization and distinguish between my private actions and my actions as a staff member of [Program Name].
14. I will not act on the job or in the community in any way that diminishes the credibility of [Program Name].

AS A TRANSITION HOUSING WORKER

15. I will not exploit the professional relationship with women and children in the Transition Housing program for any personal advantage, accept any gifts, or make any purchases from them.
16. I will respect and maintain appropriate professional boundaries in my relationship with women and children using the Transition Housing program's services, and not enter into personal friendships or association with them.
17. I will not impose my own personal beliefs or standards on women using Transition Housing program services.
18. I will be non-judgmental.
19. I will promote and practice non-violence in all aspects of my work.
20. I will work cooperatively with my co-workers and women using Transition Housing program services, and commit to resolving any interpersonal conflicts in positive ways.
21. I will not participate in or condone any dishonest, deceitful or illegal activities.

Signature of staff person: _____Date: _____

Abusive Power and Control within the Domestic Violence Shelter



This "power and control wheel" was created by **Emi Koyama** and **Lauren Martin** to illustrate how domestic violence shelters may inadvertently abuse power and control over survivors who seek services from them. In no way is this meant to discount the fact that advocates have been doing, and continue to do, extremely important and life-saving work. Rather, it is meant to incite discussion as to what we still need to work on in our empowerment-based and social change advocacy. Please contact **Survivor Project** at (503) 288-3191 or info@survivorproject.org if you are interested in distributing this wheel.

Developed by Domestic Abuse Intervention Project, Duluth, MN

Advocacy Wheel

Trust Isn't Always Easy

A woman who has been traumatized may have trouble trusting others, even people who appear to have good intentions. She also may not trust social service providers or other authority figures for a variety of reasons:

- Negative past experiences. She may have experienced important people in her life who treated her in ways that felt confusing or disrespectful.
- Fear of authority figures. She may have encountered authority figures who abused their power, discounted her or blamed her for her problems instead of helping her.
- Fear of legal sanctions. She may fear prosecution if she discloses illegal behavior such as drug use, theft or prostitution. If she has been incarcerated, she may fear going back to jail or prison.
- Fear of being judged. She may have heard repeatedly that her problems are caused by her own behavior, lack of personal responsibility, inappropriate decisions or bad character traits.
- Fear of being discounted. She may have a history of not being believed when she is telling the truth, especially if she is a survivor of violence, or coping with mental illness, substance abuse or addiction.
- Fear of encountering stereotypes. She may have encountered people who avoided or excluded her because of her race, culture, socioeconomic background, mental health status, etc.
- Fear of losing her children. She may fear that disclosure of parental substance abuse, domestic violence or illegal activities will trigger an investigation by a child welfare agency.
- If she has a mental health issue, she may fear being judged incompetent to provide adequate parenting.
- Fear of being denied services. She may fear being barred from a residential facility, denied public assistance or disqualified from other benefits if she discloses issues such as substance abuse, mental illness, prostitution or past incarceration. A participant who receives public aid may fear losing benefits if she discloses that she is living with a partner.
- Fear of losing autonomous decision-making power. People who think they know a women's needs better than she does may try to impose their own solutions and values on her.
- Fear of reprisals. She may fear retaliation from the perpetrator if she reports sexual assault to the police, seeks an order of protection against a violent partner, or reports any kind of abusive behavior directed toward her in an institutional setting.
- Fear of being scapegoated. She may fear being accused of things she didn't do. For example, if she discloses a history of substance abuse or incarceration, she may be the prime suspect if something turns up missing.

SECTION 4

Promising Practices

Reducing Barriers to Support for Women Fleeing Violence

A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use

Section 4 Table of Contents

Section 4 Table of Contents Continued..

Section 4 Summary

Promising Practices

Build in time to regularly reflect on you own, and with your team, about your current policies, procedures and practices:

- How are they reflective of the Promising Principles in Section 3?
- Are any of them counter to the Promising Principles?
- What changes might you make to better align with the Promising Principles?

Eligibility

- Mental wellness and/or substance use are not reasons for denying women access to our program; instead, focus on behaviours that may be challenging.
- Our foremost goal is to find ways to ensure women experiencing violence can be in our program, or access our supports.

Entrance/Intake

- Start building a relationship of trust and respect from your first contact with women.
- Think about what information you absolutely need. What could be part of an ongoing conversation that could take place later?
- Ask women up front if they foresee any challenges living communally, and how you might best support them.

Talking about Mental Wellness/Substance Use

- Ask with these intentions: As a means of informing services (such as safety planning or referral needs).
- Avoid making assumptions: Find out what a woman's levels of mental wellness and/or substance use mean to her.
- Always ask first: Ask if a woman is interested before providing her with information.
- Make information easily accessible: Information about connections between violence, mental wellness and/or substance use should be easily available (such as pamphlets, posters or optional groups where women can connect and share).

Section 4 Summary Continued..

Program Guidelines

- Have as few as possible!
- Create guidelines in consultation with women who require your services.
- Always explain why the guidelines are there.
- Consult with women about how you can support them to adhere to the guidelines.
- If a woman has trouble adhering to guidelines, talk it through with her—how can you support her to stay within them?

Strategies for Supporting Women

- Ask the woman—she knows best!
- Listen. Be open and non-judgmental.
- Provide lockboxes for valuables and belongings.
- De-escalate tense situations.
- Organize/facilitate groups.
- Provide or facilitate access to safe substance use supplies.
- Partner with other violence-informed agencies.
- Provide training to other agencies the women access.

Section 4 Reflective Questions

1. What processes are currently in place for you and for others in your program to reflect on the work that you do, share your knowledge and debrief, or problem-solve where challenges arise? How has this worked for you so far? How can you improve these processes?
2. In what ways do you see the Promising Principles in Section 3 reflected in your current policies and procedures that affect women with varying levels of mental wellness and/or substance use? In what ways might your current policies and procedures run counter to the Promising Principles? What changes could be made to better align your policies with the Promising Principles?
3. In what ways do your house rules and guidelines reflect the Promising Principles in Sec-tion 3? In what ways might they not align? What changes could be made to better reflect the Promising Principles?
4. In what ways do your current application and intake processes align with the Promising Principles in Section 3? In what ways might they be counter to the Promising Principles? What changes could be made to make the processes more in line with the Promising Principles?
5. What brought you to the Violence Against Women (VAW) sector? What sustains you in this work?

I have seen time and time again proof that program effectiveness is not dependent on adherence to a single program model. Instead, a set of core concepts and competencies undergirds very different—yet effective—programs.

– Marjorie Rosensweig, summarizing the importance of working from a core philosophy or respect in programming for pregnant and parenting women[i]

The Promising Principles outlined in Section 3 are really the core of any Promising Practices that appear here, or that you may work towards in your own program. They may be seen as guiding principles that are central in the development of policy and procedures, as well as the implementation of those formal documents in practice. There is no one right way to put the Promising Principles into practice in your work. In this section we provide some ideas of how your program might do this, but you will need to take some time to think individually, and with other program and/or agency team members, about how best to provide women-centred, anti-oppressive, harm reduction, relational, holistic and integrated, and flexible services in the context of your work.

Ultimately, what the services and supports for women look like will vary from program to program, depending on the context of the program, the resources available, and most importantly, the needs of the women accessing the program. Consultations with women who access your services, about their needs and their ideas for improvement, are invaluable in service design. Specialist services are not the only option for supporting women fleeing violence. Other options include working to increase capacity and/or resources in your existing programming, or providing outreach and other supports to women who are unable, or chose not to access, your Transition Housing program.[ii]

Whether you decide your program has the resources to accommodate a woman or not, your interactions with a woman should always begin from a place of respect for her and for how she has found ways to survive her experiences of violence. Focus should be on providing support around the concerns she identifies as important. At a minimum, we can integrate awareness of the connections between violence against women, mental wellness and/or substance use into our policies, procedures and practices. Regardless of the constraints we work within, **simply shifting our thinking from "what is wrong with this woman?" to "what has happened to this woman?" can change the way we approach our work.**[iii] From there, think about how your program might put the Promising Principles into practice in a way that makes sense for your program and the women you support.

The broader support of anti-violence services that assists women in finding housing, income support, and connecting with other women needs to be acknowledged as contributing to helping women reduce or stop their substance use... Women with substance use problems can benefit from the holistic, non-stigmatizing, empowering and safety-focused approaches of anti-violence services.

– BC Centre for Excellence for Women's Health[iv]

4.1. Assessing our Current Policies, Procedures and Practices

As advocates our primary goal is not to serve as substance abuse counselors or police officers. Exercise caution. Don't use an individual's substance use as an excuse to 'kick someone out' or 'make them go to treatment.' Deal with each person as an individual and decide how to proceed on a case by case basis. Remember batterers can be lethal. Help program participants develop a safety plan and explore workable options. What can we do to support someone where they are? How can we leave paths open, build bridges, develop alternate housing options and partner with other providers to support empowerment, autonomy, safety and sobriety for those whose addiction creates barriers and increased risk for harm? Every time a battered woman is denied access to help due to substance abuse issues a batterer benefits. Don't forget that. Don't allow it to happen at your program. – *Alaska Network on Domestic Violence and Sexual Assault*[v]

The first step of putting the Promising Principles into practice is to take stock of your current policies, procedures and practices (see glossary in Appendix for definitions of these terms). What are you currently doing that "works" for women? Where can you make changes? For example, having processes so that women can provide feedback on their experiences through established advisory groups or surveys, will give you guidance. You may consider having a colleague do a "walkthrough," acting as a woman would when she is accessing services at your agency. The person can provide valuable feedback on what they found helpful, as well as recommendations for improvement.

Reflecting on current services will require participation by Board members and Management who are responsible for development and approval of policies and procedures, and frontline staff who put those policies and procedures into practice. There will need to be ongoing communication between all of these people for the process to be effective.

When thinking about your policies and procedures, or working with women at risk of violence, a simple guiding question is "how is this benefiting the woman I am supporting?" Questions to consider as you go through this section and reflect on your policies, procedures and practices:

1. In what ways are your current policies, procedures and/or practices reflective of the Promising Principles in Section 3?
2. In what ways might your current policies, procedures and practices be seen as counter to the Promising Principles?
3. What changes could be made to better align your policies with the Promising Principles

4.1.1. Building in Time for Reflection

It is not our differences that divide us. It is our inability to recognize, accept and celebrate those differences – *Audre Lorde*

Depending on our own social locations, such as class, culture, experiences and other factors, many of us, as women, have been socialized to avoid addressing conflict directly. This is but one small part of a socialization that both puts us at risk of, and reduces our

risk for, male violence. Conflict can often arise when reviewing practices to determine whether a particular policy, procedure or practice meets the program's larger aim of equality for women and resistance to sexism, racism, classism, homophobia, heterosexism, ableism (and more). Discussions about practices are often avoided for fear of further conflict. However, if not addressed in a positive, team building way that embraces learning, tensions will continue at the level of practices. Left unaddressed, these tensions can quite quickly become conflict between workers. Conflicts in values can be concealed when they are dismissed as "personal conflict" or a "personality clash," and workers may become frustrated or feel undermined by colleagues' approaches with residents.

Building in time to review program policies, procedures and practices and to discuss whether and to what extent they meet the overarching aims of the program gives workers the opportunity to get to the root of conflicting approaches. **There are many benefits to ensuring your team has regularly scheduled time to critically analyse program practices.** Critical analysis of program practices leads to better services for residents:

- Stronger teams with renewed energy, whose members understand and can draw from one another's values, experiences, skills and knowledge. This creates a "learning community" in which members value their ability to teach and learn from their colleagues, and their fear of "making mistakes" is reduced.
- Stronger, broader sense of purpose, commitment and vision to end violence against women.
- Increased creativity in problem-solving.
- Reduced conflict between staff and between staff and residents.
- Reduced isolation in everyone's day-to-day work.
- Increased employee retention (see the end of this section for more on getting the right peo-ple into your organization).

Reflective Questions

What processes are currently in place for you and others in your program, to reflect on the work that you do, share your knowledge and debrief or problem-solve where challenges arise? How has this worked for you so far? How can you improve these processes?

Resources and tools to help you think about being more violence-informed:

Substance Abuse and Mental Health Services Administrations' A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness.
www.homelessness.samhsa.gov/ResourceFiles/a4ik4an3.pdf

BC Centre of Excellence for Women's Health guides on Developing Trauma-Informed Practices and Services
www.coalescing-vc.org/virtualLearning/section1/default.htm

4.1.2. Policies Related to Mental Wellness and Substance Use

Women are anaesthetizing themselves to avoid feeling the pain of all the grief and loss they have suffered. The anticipation of confronting this pain and sadness makes stopping their drug use a major challenge. We are there to support them and to assure them they are making the best choices they can. We do not judge them for the choices they make.

– Staff Member, YWCA Crabtree Corner[vi]

Reflective Questions

In what ways do you see the Promising Principles in Section 3 reflected in your current policies and procedures that affect women with varying levels of mental wellness and/or substance use? In what ways might your current policies and procedures run counter to the Promising Principles? What changes could be made to better align your policies with the Promising Principles?

Policies and procedures should be seen as living documents—they need to be reviewed, adapted and updated regularly. Review your policies and procedures related to providing services for women to ensure they are reflective of the Promising Principles outlined in Section 3.

As you review existing policies and procedures or create new policies, ask:

- What is the purpose of the policy?
- What is the intention behind the policy?
- How does the policy influence the service women receive?
- How do women accessing our services benefit from the policy?
- Does the policy make it difficult for some women to access your services?

Some programs choose not to have specific policies around mental wellness and/or substance use because they see changes in mental wellness and substance use as normal responses to violence. They may even state outright that levels of mental wellness and/or substance use are not reasons to exclude women from services. Other programs have developed policies stating their position on mental wellness and/or substance use, how they are connected to violence and the importance of harm reduction approaches (such as the South Okanagan Women in Need Society's harm reduction policy in the provided in the Reducing Barriers Appendix page 29). Whether you decide to have a separate policy on mental wellness and/or substance use, or choose to integrate the issues into other relevant policies, it needs to be clear that **mental wellness and/or substance use are not reasons to exclude women from services**—focus must be on the specific behaviours that may be challenging to accommodate in communal living settings.

For sample admission, mental wellness, substance use and harm reduction policies, see the Appendix.

Information on what to consider when developing policies in shelter and Transition Housing environments:

Sample Drugs Policy—For Domestic Violence Services, Stella Project
www.avaproject.org.uk/media/15633/sampledrugspolicyfinal.pdf

Sample Drugs Policy and Guidance Notes, Drugs and Housing, United Kingdom
www.drugsandhousing.co.uk/htdp2011.pdf

4.1.3. Eligibility Criteria and Considerations

We recommend that programs examine their criteria for services and avoid blanket service restrictions for women seeking shelter or other services based solely on their alcohol or drug use history. In many cases, the batterer is more of an immediate threat than the risks associated with substance use.– Washington State Coalition Against Domestic Violence[vii]

In our programs, we all want to provide women with a safe, supportive environment where they are free from violence. But sometimes we prioritize some women's safety over that of others, based on their levels of mental wellness and/or substance use. We often believe that only a select few women are impacted by these concerns, but we now know that violence affects levels of mental wellness and/or substance use for most women who experience violence. If we were to refer every woman for whom this was true to other services, our Transition Housing programs would be rather empty. **Instead of screening women fleeing violence who have varying levels of mental wellness and/or substance use out of our services—with the intention of keeping other women, youth and children safe from them—we need to find ways to reduce safety risks for all women.**

We also need to be aware of how our programs' policies and rules may disproportionately impact some women. Requiring women to take medications for mental wellness concerns or to stop their use of substances altogether to gain access to our services can be unrealistic and unsafe for some women, especially if substance use or non-compliance with medication has been an effective coping strategy or a means of staying safe. **Focus must be placed on behaviours that cause problems, rather than on mental wellness diagnoses or substance use levels themselves. Behaviours that are not conducive to communal living environments can come from any of us, whether we struggle with substances and mental wellness or not.**

Currently, hundreds of women are turned away from Transition Housing programs in BC each year due to assumptions that the women's levels of mental wellness and/or substance use may cause problems in communal living environments.[viii] For many women, changes in mental wellness and/or substance use are responses to the violence they are experiencing. We are essentially turning women away for their responses to, or attempts to cope with violence.

As anti-violence programs, we are well positioned to support women through all of the effects of violence. Rather than seeing these issues as separate ("A woman who has mental wellness and/or substance use issues is accessing our program"), women, anti-violence advocates and researchers are saying we need to see them as interconnected ("A woman who has experienced violence is also experiencing effects on her mental wellness and/or substance use"). The ultimate goal here is to ensure that women feel they are in a safe, non-judgemental environment where they can openly talk about the experiences/effects of violence without fear of losing access to support.

Viewed this way, when determining whether a woman is eligible for our program our focus should be on:

- whether the woman has experienced violence
- whether the woman feels she would be a good fit for or would benefit from our program
- whether we can accommodate the woman at this moment.

Of course, we must work within the resources we have; generally speaking, Transition Housing programs are understaffed and under-resourced. For example, single shifting can make it difficult to take the time we would like to with the women we support. Little or no time for staff crossover makes it almost impossible to debrief or problem solve around challenging situations. Even the

physical layout of some Transition Housing programs, where women must share bedrooms and washrooms, can make it difficult for women and for program staff. Some communities have almost nowhere else where women feel safe to go

We all have work to do to ensure that our programs receive recognition and resources that more accurately reflect the amazing work we do. Still, we need to do the best we can with what we have for women escaping violence.

Whether we are able to physically shelter a woman or not, we can find ways to support her by finding out what she needs, exploring her options with her and supporting her decisions. For example, some programs find ways to continue relationships advocating for and supporting women by phone, through outreach, or through other programs in their agency. Some programs in BC have office space, or space in other non-profit service agencies in their community, where they can support women in a safe place outside of the Transition Housing program.

As mentioned in the Introduction to this toolkit, although many anti-violence workers believe they need specialized knowledge, the Promising Practices identified internationally for supporting women who have experienced violence and who have varying levels of mental wellness and/or substance use are rooted in what you are already doing—treating women as experts of their lives, helping women identify their options around the needs they identify, providing information they may not have and supporting them on whatever path they choose to walk.

Domestic violence organisations should be committed to actively working towards providing an equivalent and inclusive service for all women, whatever their needs. – Women's Aid[ix]

4.1.4. Program Rules and Guidelines

Reflective Questions

In what ways do your house rules and guidelines reflect the Promising Principles in Section 3? In what ways might they not align? What changes could be made to better reflect the Promising Principles?

Blanket policies and rigid rules increase the likelihood of women being either denied service or evicted, or otherwise forced to comply with treatment or other expectations against their will. As such, they can easily result in women being revictimized. Such misuse of power is a form of institutional oppression that reinforces the abuse and stigma clients are all too familiar with, and contradicts the goals of anti-violence services. 'Guidelines' are much more reflective of a harm reduction model, since they provide a range of options and allow for more flexible, individualized responses. .... These guidelines must reinforce the key service goals of safety and inclusion, and helping women identify and get what they want or need when they are ready for it. The underlying question is always, 'what kind of support or help does this woman need from us to make this next decision or take this step?'

– South Okanagan Women In Need Society Harm Reduction Policy (see Reducing Barriers Appendix)

Transition Housing work began as a significant social movement to bring about women's equality by eliminating all forms of violence against all women. Feminists who opened transition houses during the 1970's and 1980's saw violence against women as a serious impediment to the equality they were committed to achieving. Transition Housing work was grounded in the belief that modeling equality and resisting sexism in everyday practices would demonstrate to residents that a society based on equality was possible. By demonstrating that women's equality was possible, all women would join together and demand equality.

Toward that goal, Transition Housing workers strove to model egalitarian relationships between volunteers, staff and residents. To practice women's equality, many Transition Housing organizations operated as collectives. This changed over time as Transition Housing organizations began to grow. With the addition of programming throughout the 1990's (such as additional Transition Houses, Community Outreach, Children Who Witness Abuse and Stopping the Violence Counseling programs), organizations became large, multi-sited and complex, and most moved to hierarchical or modified-hierarchical modes of management. However, identifying and resisting sexism and other forms of oppression in our practices continues to be important. Different Transition Housing programs do this in different ways, but **a general approach is to examine our ways of operating based on questions such as "how does this practice promote women's equality and/or resist sexism?" If practices are seen to reinforce sexism or other forms of oppression by exerting control over women, they are rejected.**

For example, establishing and enforcing rules within shelters demonstrates the power differential between residents and workers. **Women-centred practices require that we work with as few rules or guidelines as possible so that women do not feel like they have simply exchanged one source of oppression (their abuser) for another.** At the level of practice, we are all inclined to introduce rules in response to some kind of problem we have experienced, to avoid that problem in the future. This inclination tends to make our lists of rules grow. With a growing list of rules, we reduce the numbers of women who can follow our rules. Although they may be created with good intentions, women who have stayed in Transition Housing programs find that rules (such as the enforcement of particular bed times, awake times, curfews, what food is to be prepared and eaten, and when) feel similar to, if not the same as, the environment that they have just fled.

One of the many ways we can avoid reproducing the environment of domination women have fled, and model respect and equality, is to have as few "rules" as possible. By critically analyzing your house rules you are likely to find ways to reduce your rules, and increase women's ability to follow some general guidelines. A few sensible guidelines, along with an explanation about why your program has the guidelines that it does, will increase the likelihood that women will understand and respect the guidelines.

When you review your house rules, you may find some rules that once made sense but no longer do. There are times we forget why we do the things, because we have been doing them for so long it has become "natural;" we forget to question, because it has become "common sense." When asked why we do things the way we do, it is not unusual to hear ourselves say "because we have always

done it this way." For that reason, **it is always good to remember the history of what led to the practice, and to rethink whether or not the practice continues to meet our overall aims, vision or goals.**

Most Transition Housing programs have "curfews," but that rule (or guideline, depending on your program), was implemented at a time when Transition Housing programs were not staffed 24 hours per day, seven days a week. The rule/guideline was to ensure that all residents were safe before staff went home for the night, or for those who carried a pager after hours, staff could sleep knowing that all residents were in and therefore safe. But many Transition House programs continue to operate with an early "curfew" for residents, even though, with 24 hour staffing, the curfew no longer serves the original purpose.

By critically analyzing your practices, you may find that a guideline continues to work well for the women you serve, or that it needs modifying, or eliminating altogether. **Involving residents and/or former residents in discussions concerning your guidelines helps to ensure that staff discussions and decisions are informed by those affected, and ensures that your practices are women-centred.**

Other questions to consider when reviewing house rules and guidelines include:

- Is this rule necessary for house safety? Who is this rule intended to serve?
- If you were a resident tomorrow, how would these rules feel to you? Would you be able to comply with the rules in a state of crisis?
- If you have children, would you be able to comply with the rules related to them, including bed time rules? Would your teenagers be able to? Would this be a time at which you would want to be authoritative with your children/youth to ensure their compliance with rules?
- If you were not able to get your children/youth to comply with the rules such as "bed times," would you worry that your parenting skills would be negatively judged? Would this be the best circumstance under which to "assess" your "parenting skills"? Would you worry that you might be asked to leave?

Authors with the Stella Project, a project to reduce barriers for women experiencing violence who use substances in the United Kingdom, say it is helpful to think of a few key messages to convey to staff and residents in your Transition Housing program through your policies and guidelines. We have adapted their suggestions here:[x]

- We all have the right to live free from violence.
- Changes in mental wellness are normal responses to experiences with violence.
- Substance use often enables women to cope with their experiences of violence and with the effects of violence on their levels of mental wellness.
- Not all women agree with a mental wellness diagnoses.
- Not all substance use is problematic.
- Any behaviour that is offensive or disruptive, whether related to varying levels of mental wellness and/or substance use or not, will be addressed.
- Negative language such as "crazy," "schizo," "junkie," "alkie" or "addict" are unacceptable ways to refer to women.
- All prescription medications should be safely stored.
- Relevant for some, but not all programs—we ask for no Illegal drug use, supply or manufac-turing in the building.

See Section 4, Appendix (page 63) for a Stella Project sample letter advising residents on substance use policy.

4.2. First Contact and Intake Considerations

We can start by respecting a woman as an individual, before we begin asking her questions. The fact that she has come in to receive services does not give us the right to pry into her life.

– Anti-violence advocates Angela MacDougall, Tessa Parkes, Sarah Leavitt and Susan Armstrong, Freedom From Violence toolkit[xi]

4.2.1. First Point of Contact with Women

The importance of creating an open, respectful, welcoming relationship from the first point of contact cannot be overstated. This initial conversation gives workers the opportunity to share information about the Transition Housing programming, and for the woman to decide whether the programming is a good fit for her needs.

Key points to remember for your first point of contact with women:

- Assess the woman's current level of safety.
- Inform her about your confidentiality policy, or limits of confidentiality.
- Ask her what she needs, or is looking for.
- Provide information about the program:
  - Services you offer.
  - House rules/guidelines.
  - What the house is like (communal living, if she will have her own room/suite or will share).
  - Your policies and practices around mental wellness and substance use (for example, that you support women no matter where they are at in terms of mental wellness and/or substance use).
- Ask if the program sounds like a good fit for what the woman wants and needs.
- If not, find out more about what she is looking for and connect her to services in your area (if available) where her needs might be met, or where you/she will get more information on resources that will meet her needs.
- If she says the program sounds like a good fit, explain what the next steps are/will be:
  - What is the application process like, if Second Stage.
  - What is the intake process like, if there is one.
- If she has concerns or questions about the program, answer them openly and honestly:
  - If she has concerns about living with other women who have varying levels of mental wellness and/or substance use, explain that changes in these areas are a normal response for women who have experienced violence. Let her know that the program staff are there to support her and to help her feel safe. Let her know that there are rules and boundaries around behaviours in the house and that these rules apply to all women.
  - If she is cutting down on or stopping substance use altogether and is worried about living with other women who may currently be using substances, let her know that staff are available to talk to and to plan how best to support her as she continues to cut back/curb her use of substances. Tell her that women often find their levels of substance use are affected by violence. You may also let her know about any links you have with the substance use sector in your program, particularly if she requires medical or withdrawal management supports to cut

back on or abstain from substances. (see 4.4.6 Working With Women Who Use Substances, page 39)
- If the woman is still unsure, you may want to connect her with other anti-violence services that may be a better fit, or find out if you can support her through outreach (see 4.5.1 Making Effective Referrals, page 45).

The first contact is an opportunity to build a trusting relationship from the beginning, which can help create space where women are able to talk about their experiences of violence, mental wellness and/or substance use; to plan for their safety with these factors in mind; and to access support should they want it. In addition to these considerations, you'll want to consider the dynamics in the program. For example, some programs try to ensure that women who need extra support have a room to themselves, for the comfort of the woman and others in the program. Here, though, it is important not to make assumptions about what women want or need.

Some questions to reflect openly and honestly on to assess your first point of contact for women:

- Is the first person a woman contacts welcoming, respectful, and engaging on the phone or in person?
- Does the woman receive clear explanations and information about the program and services available to them?
- Would the woman feel comfortable/motivated to enter the Transition Housing program?

4.2.2. Intake or Entrance Process

Making the decision to leave one's own space and go to a Transition Housing program can be daunting for women, and having to answer a series of personal questions can feel quite invasive. Explaining the process, and why you are asking questions, may help women feel less intimidated and more in control of the situation. Ask the woman whether she would be more comfortable filling out the intake or entrance form herself or if she would prefer to go through it with you. Provide rationales for why you are asking the questions you are, and how the information will be used—verbally, or directly on the form for women who opt to fill it out themselves. Be adaptable; women may be tired, upset or may have challenges related to speaking English or to literacy. Having cultural interpreters and translators available will help ensure a woman's comments and experiences are understood in the context of her culture. It is also important to **let women know they are not required to answer any questions they are not comfortable responding to, and that not answering will not impact their access to services.**

Think of the entrance or intake process as a chance to start building a relationship with the woman you are working with and to learn about what the woman needs. Your agency probably has its own intake or entrance process in place, but generally you'll want to address urgent needs first—most importantly, her safety from other people. Other concerns or items you will want to discuss:

- Is the woman injured?
- Does she require medical attention?
- With respect for her safety, is there any possibility she will be at risk of seizures as a result of experiencing withdrawal from long term alcohol or benzodiazepine use?
- Does she need food and/or sleep?
- Confidentiality policies.
- Fire or emergency safety.
- House guidelines or rules.

- Any needs she feels are important for you to know, or supports she may require.

Check in on how the woman is feeling and use that as a gauge for how to proceed. Longer conversations about the woman's needs and options can and should take place over time, giving you the opportunity to build a respectful, trusting relationship and to support women on whatever path they choose to walk.

Supporting women and partnering with them to enhance their safety involves creating authentic, trusting relationships and open conversations. This relationship will help you talk together openly about how she has strategized for her safety, the supports she has in place, what gets in the way of her safety and how you can support her. You may want to ask if there is anything she thinks is important for you to know, or if there is anything you can do to make her time at the program more comfortable. **Asking for strategies for how best to work with her, or support her, are good practices for every woman we meet.**

The Ontario Association of Interval and Transition Houses identify key questions to think about when reflecting on the intake or entrance process in your Transitional Housing program:[xii]

- How would you describe the intake area, if there is one? Would you describe the space as comfortable and inviting?
- Do women receive clear explanations and information about the program and services available to them?
- Do staff explain why they are asking the questions they do ask? Is it clear what is done with any information that is collected? Are women told they are not required to answer anything they are uncomfortable answering? Is it made clear that declining to answer an intake question will not preclude a woman from service?
- Are questions asked in a non-judgemental way?
- How invasive would the process feel? Is information collected that may not be necessary?
- Do women get a clear and appropriate message about their rights and responsibilities?
- Do providers communicate respect for the women's life experiences and history?

4.2.3. Asking about Mental Wellness and Substance Use

[P]roactive efforts to identify chemical users among a population of battered women residing in shelter is recommended only in those programs that welcome chemically-involved battered women into their shelter and are prepared to respond supportively rather than punitively. – *Theresa Zubretsky*[xiii]

In Freedom From Violence: Tools for Working with Trauma, Mental Health and Substance Use, Tessa Parkes sums up the controversies around assessing for mental wellness and/or substance use when women access anti-violence services:

- Questions may be asked as a way to screen women out of programs rather than a way of understanding the women's situation, to provide the most effective service we can.
- Women are referred to other programs, whether they identify a need for them or not—and even if they are fleeing violence.
- Programs women are referred to may not have a solid understanding of how violence

affects mental wellness and/or substance use, and may put women at increased risk of violence.
- if service providers record information about a woman's mental wellness and/or substance use, that information may be used by an abuser against a woman, for example to argue that she is an "unfit mother."[xiv]

On the other hand, Parkes argues that there is value in asking about mental wellness and/or substance use, for example, to improve advocacy and provide opportunities for more open and realistic safety planning.

Transition Housing programs have traditionally fallen under the first grouping, referring women with varying levels of mental wellness and/or substance use to other programs with the intention of keeping other women, youth and children in the program safe.[xv] **Asking as a means of "screening women out" places women in a position where they must be untruthful about their mental wellness and/or substance use to access support programs, and sets the stage for a disempowering relationship.** This may be why researchers in BC have found that universal screening for substance use is not always effective.[xvi]

Before asking about mental wellness and/or substance use, Parkes recommends we think about:

- What is the purpose of discussing mental wellness and/or substance use with women?
- What are we going to do with the answers? How will they assist us to work with her?
- Are women with varying levels of mental wellness and/or substance use the women we find most challenging to work with?
- Are we using assessment to reduce our own anxiety or increase our own comfort?

As with any other question we ask, **the most appropriate reason to ask about mental wellness and/or substance use is to inform safety planning processes, or to otherwise improve our services and advocacy for women.** Even if that is our intention, our own beliefs and assumptions can impact how we behave, what we say and how we are received. Women who have experienced violence are intuitive and perceptive and can pick up on any unintentional signals we may be giving, that we are uncomfortable with the conversation.

Some important things to remember when talking to women about mental wellness and/or substance use:

1. Ensure privacy. Children should not be present.
2. Let the woman know why you are asking the questions that you are, what you will do with that information and who will have access to that information. Remember that if she has children, she may be afraid that information will be used against her by her abuser and/or Child Protection agencies.
3. Ask questions through a conversational approach.
4. Ask questions in a respectful, non-judgmental manner.
5. Assure the woman that her levels of mental wellness and/or substance use will not impact her access to your program or support (if that is true).
6. Let the woman know that mental wellness and substance use often fluctuate as a result of violence.

For example, you might ask about mental wellness and/or substance use:

> *"Many women say that it is not just physical injuries they are healing from. The psychological effects of violence can be just as, if not more, harmful. Have you noticed any changes in the way you feel?"*

Or you may say something more general:

> *"Some women find that their mental wellness and/or use of substances are affected by the violence. If this is something you want to talk about, we are here to listen."*

Or you might find out what service options to provide:

> *"Are there any other areas we can help support you with?"*

The goal here is not to find out specific details about mental wellness diagnoses, medical histories or specific substances women are using (legal or illegal), but to find out how best we can support them. If your program has a policy that women cannot use substances on-site, let women know this and find out whether this will present a problem for them. **Make it easier for women to be in your program without contravening rules by talking openly about any concerns they may have, and strategizing together.**

A conversational approach runs counter to universal screening' [or standardized] approaches, but makes a safe, open, meaningful discussion more likely. Universal screening for substance use may not be very useful since it is usually done before safety is established.

– BC Centre for Excellence for Women's Health[xvii]

Rather than asking direct questions upon first contact or in an intake process, some programs focus on relationship-building, and on creating space for women to talk with anti-violence advocates about their levels of mental wellness and/or substance use over time:

- Let women know the eligibility criteria for your program and explicitly mention that levels of mental wellness and/or substance use will not prevent women from accessing service.
- Acknowledge that being in a new, communal living environment can be stressful for any woman and find out how best you can support her in this stressful time. For example ask, "Many women feel overwhelmed when they come here. Is there anything in particular we can do or say that helps you feel better when you feel really stressed?"
- Inform all women of any connections your program may have with mental wellness and/or substance use services (and any other sectors or service agencies) so women are aware of their options.
- Have information accessible to all women about the impacts of violence on mental wellness and/or substance use.
- Provide supplies for safe substance use (many programs provide sharps boxes; some provide clean syringes which can be in locked cupboards in each room or in a central area) and let women know they are available.

Do not be offended or take it personally if you feel the woman is not open with you. Her response is not about you. Women who have talked openly about their mental wellness and/or substance use in the past may have lost access to services or encountered negative and judgemental responses. Some women have lost custody of their children, their jobs or their homes. Mental wellness

and/or substance use are stigmatized subjects and she may not be ready to talk about them. It takes time to build a trusting relationship. Respect and support her decision to disclose how much or how little she is comfortable with. Let her know that you are there to listen and be sure to make yourself as accessible as you can so that she can see that your offer to listen continues throughout her stay. (See Section 4 Appendix *"I want to know how to deal with the manipulations used to avoid substance abuse issues",* page 61)

Most importantly remember that for many women, mental wellness and/or substance use fluctuate in response to experiences with violence. These in themselves are not problematic and thus should not be grounds for admitting/not admitting a woman. **The most immediate concerns during our first contact with a woman are to assess whether or not she is safe, has any immediate medical concerns, and to identify her needs and find out whether she thinks our program can meet those needs.** The goal is to facilitate access to services rather than to screen women out.

Not all survivors need or want specialist support. For many, symptoms resolve when they are safe. Others do not want to address their feelings until practical issues are settled.

– Greater London Domestic Violence Project[xviii]

4.2.4. When a Woman Discloses

Conversations with women to learn about their needs, and how we can support them, are ongoing. We will likely not have the trusting relationship with women we need, in order to have some of these conversations, from the get-go. Since levels of mental wellness and/or substance use and feelings about them are always changing, our conversations may be different day to day.

Our goal as anti-violence workers is to support women in staying safer—this could range from simply providing a safe place to stay, to working to develop plans for long term safety. This goal does not change if a woman tells us she has varying levels of mental wellness and/or substance use. Try not to make assumptions or judgements about what a woman's level of mental wellness and/or substance use means for her safety, or for the safety of others (for example, her children or other residents in the program). Find out what these levels mean to her, how they help or hinder her safety and what we can do to best support her.

While a response may be "maladaptive" in that it causes more pain—self-harm, avoidance of intimacy, or alcohol and drug abuse can cause problems in and of themselves—it does not mean that the woman responding in this way is mad, and is thus worthy of psychiatric diagnosis. Understanding the meaning of her response, and the way in which it evolved in reaction to an untenable situation, can be the first step in developing more "adaptive" ways of making sense of experience and surviving – Jane Ussher, researcher and author[xix]

The Ontario Association of Interval & Transition Houses has produced a film called For Her Own Good that provides a glimpse into the lives of five strong women who explore experiences with mental wellness diagnoses

and anti-violence services. Find it in the video section of their website **www.oaith.ca/resources/videos.html**

If a woman shares with you that she has a mental wellness diagnosis

Create safety for her to talk about her mental wellness

Let her know that her level of mental wellness will not prevent her from staying in the program. Share with her if/how you will be making notes on a file.

Listen

Listen to what she has to say and how she feels about it. Be aware of the language you are using as well as your body language—be open and non-judgemental.

Find out what the diagnosis or label means to her

This will be an ongoing conversation you have over time, as levels of mental wellness and feelings about those levels are always changing.

Women are sometimes given diagnoses without mental wellness professionals knowing about, or considering, their experiences of violence. Some women may be happy to have a term for the ongoing challenges they have experienced related to mental wellness; others may not, or may be unsure. Many women see fluctuations in their levels of mental wellness as a response to their experiences of violence. Whether a woman feels a diagnosis fits for her or not, it is important to remember that mental wellness is just one aspect of who she is and does not reflect her whole identity.

Identify potential safety concerns with her and how you can best support her

We do not necessarily need to know any specific diagnoses she has received or thinks she might have, but we may explore what behaviours or symptoms she thinks are connected to her levels of mental wellness and how they are impacting her safety.

Questions might include:

- How can we tell if she is experiencing these symptoms? And how does she want us to support her if she experiences them while in the Transition Housing program?
- Does she see her mental wellness connected to her experiences with violence?
- Does it help her or hinder her from staying safe? Or both? Is she interested in thinking or talking about these connections?

Help her understand the connections between violence and mental wellness

For many women, changes in levels of mental wellness are very much connected with their experiences of violence. Changes in levels of mental wellness are a normal response to stress and danger. This may or may not be how she feels, and she may or may not be ready to explore how she experiences these connections with you. Providing information on these connections, for example in the form of literature or in casual or more formal group discussions, may help create a safe space for women to talk about their experiences of violence and mental wellness.

Take the lead from the woman

Respect a woman's autonomy and ability. Ultimately, it is up to the woman to decide whether or not a mental health diagnosis/label makes sense or applies to her experiences. It is also up to her to decide whether she needs or wants support around her levels of mental wellness. Ask before providing any information or options. Listen to what each woman you meet asks for, and collaboratively

make a plan of support based on the needs she identifies. Be aware that some women may benefit from more concrete support to develop and follow plans, especially if they are living with cognitive challenges.

The feminist principle of meeting a woman where she is at is central to the harm reduction approach because it recognises that many social factors create harm for women. It works without judgment and engages with the complexity of women's lives. It is pragmatic and practical through its creation of different 'entry points' for women to access services and in-terventions. A harm reduction approach encourages service providers to work with women along a continuum of substance use, not just helping those who are able to abstain. –
Tessa Parkes, on Battered Women's Support Services[xx]

If a woman shares with you that she uses substances

Create safety for her to talk about her substance use

Let her know that her substance use will not prevent her from staying in the program. Share with her if/how you will be making notes on a file.

Listen

Listen to what she has to say, and how she feels about it. Be aware of the language you are using as well as your body language—be open and non-judgmental.

Find out what her substance use means to her

We do not need to ask her detailed questions about what or how much she is using (except in relation to safety planning in the case of high-risk withdrawal, such as with heavy alcohol or benzodiazepine use). We do want to know how she feels about her substance use, or whether it is causing her problems.

If she feels her substance use is causing problems for her, find out whether she is interested in seeking support. If your program does not allow substance use while there/on-site, you might also ask if she thinks she might need support to be able to stay in the program. Have conversations to make a plan about what should happen, if she comes back to the program having used substances or if staff fear she is overdosing. Having these conversations beforehand may help reduce stress and uncertainty if those situations come up. Talking about how she might help support other women who are cutting back on or eliminating their substance use in the program might help to prevent problems from coming up as well.

Have these conversations in a nonjudgmental way, trying not to make assumptions about how her substance use is connected to her safety. Whatever she feels about her levels of substance use, remember that substance use is just one aspect of her life. Women who use substances are often seen as "drug users" before anything else—but they are also women, mothers, sisters, aunties, workers and community members, and may have a number of other identities they feel are more defining and significant than their substance use.

Normalize the use of substance(s) at this time, and identify potential safety concerns

For many women, the period after leaving an abuser (whether short or long term) is a time when her substance use may increase. She may see this as a helpful coping strategy.

Share with her how this is common, and help her explore how her substance use may help or hinder her at this time.

Remember that women who cut back on their substance use may be at increased risk of violence from their abusers, who may feel they are losing control over the woman. At the same time, increased substance use may also present more risks—it is important to explore all of these possibilities, and to collaboratively develop plans that will best support her safety.

Take the lead from the woman

Respect a woman's autonomy and ability. Ask the woman for permission before providing information to her. Let her know you are there to talk, if she wants to. It is up to her to decide whether, and when, she needs or wants support around substance use.

If she is interested in information or assistance, help her to identify small, achievable steps to support overall success in making changes. Listen to what each woman asks for, and help her make a plan based on the needs she identifies. Be aware that some women may benefit from more concrete support to develop and follow plans, especially if they are living with cognitive challenges.

Stay humble and curious. Resist assumptions that changes in her substance use are the first priority. Remember that not all women who use substances experience problems associated with substance use. Women may, or may not, be ready to explore how they experience connections between violence and substance use. Try not to assume she doesn't know—she may just not be ready to talk about it.

A woman's decision to keep using or to decline treatment, advocacy or shelter should not be viewed as failure. Recovery is both an option and a process that can take time. – Washington State Coalition Against Domestic Violence[xxi]

In general, when talking with women about their levels of mental wellness and/or substance use, listen carefully and be open to hearing what women say they want or need—they know their own situations best, and how you can best support them. Be honest about what you can and cannot do for her, and what you do and do not know. Offer assurance that if she is interested in support about her level of mental wellness and/or substance use, at any time you can connect her to knowledgeable service providers in your community (if that is the case!)

In the Freedom From Violence toolkit, Tessa Parkes identifies unhelpful responses as including:

- *Arguing, disagreeing, challenging.*
- *Judging, criticizing, blaming.*
- *Warning of negative consequences.*
- *Seeking to persuade with logic or evidence.*
- *Interpreting or analyzing the reasons for resistance.*
- *Confronting with authority.*
- *Using sarcasm*[xxii]

4.3. Applications, Intake Forms and Record Keeping

Keep in mind that anything you record may

be subpoenaed and/or end up in the hands of the abuser. **We do not recommend recording information about women's levels of mental wellness and/or substance use.** This information can negatively impact women if abusers are able to get hold of it. For example, if subpoenaed, the information could be used against her in child custody cases or to undermine her credibility in criminal cases. Before asking for or recording any information about a woman, ask yourself:

- What is the purpose of collecting or recording the information? How will it better your services for her?
- What will you do with the information?
- Is the information your perspective on the woman's situation, or her own?
- Could the information be harmful to the woman? Will it have an impact on her access to services (yours, or others)? Could it be used against her in legal settings? How could an unsympathetic third party interpret the information?

Reflective Questions

In what ways do your current application and intake processes align with the Promising Principles in Section 3? In what ways might they be counter to the Promising Principles? What changes could be made to bring the processes more in line with the Promising Principles?

BCSTH and the Ending Violence Association of BC have produced Records Management Guidelines that can be consulted for in-depth information on record keeping. Available online at **www.bcsth.ca** in our General Resources section.

4.3.1. Intake Forms

While you may record information that would be pertinent in case of a medical emergency (such as allergies, medications required, risk of seizures), **we do not recommend recording information about women's levels of mental wellness and/or substance use.** This information can negatively impact women if abusers are able to get a hold of it. If for some reason you must record this information, you may opt to use a checklist indicating that the question has been asked, rather than whether the answer was "yes" or "no." Whatever intake form you use, keep in mind the principles above. (See the Reducing Barriers Appendix for a sample Intake Form)

Some key guidelines to consider when determining what information you will collect or record:[xxiii]

Obtain the woman's written consent before collecting any personal information about her

Explain how you intend to use the personal information being collected, and obtain the woman's written consent to use the information in this way. In general, any information-sharing with other agencies should be done with the woman's consent.

Collect only the information that is necessary to determine the appropriate service, and to deliver the specific service being requested

Some multi-service agencies use both a generic and a secondary intake form. The generic form requests only the basic information necessary to determine which service the woman requires. Once the woman is referred to that service, the secondary intake form requests information needed to effectively deliver that service.

Women have the right to be informed about the nature of the service they receive and the contents of any documentation of that

service
Women have the right to request to see and/or have any information that has been recorded about them, and to request that it be changed.

(See the Reducing Barriers Appendix for a sample Intake Form from the BCSTH and EVA BC Record Management Guidelines.)

4.3.2. Application Process for Second Stage Housing

Women applying to Second Stage Housing may or may not be in the same state of crisis as women accessing Transition Housing or Safe Home programs. The Promising Principles and Promising Practices are, of course, just as applicable in your work with women applying to Second Stage Housing.

Before collecting any information about women, let them know why you are asking what you are, and what the information they provide will be used for. The record management guidelines mentioned in the Intake Section above apply here, most importantly: collect only the information that is absolutely necessary to provide service to the woman. Relevant information might include:

- A brief overview of your program , services available and any program guidelines.
- Clear rationales for why you are asking what you are and what you will do with the information.
- Name.
- Contact information.
- Number and ages of children who would be coming with her.
- Why the woman thinks she would benefit from the Second Stage program.
- Any supports or services she may be interested in.
- Any supports she currently has in place.
- Whether a unit that is accessible for women who experience challenges with mobility is required.
- Relevant income information.

Collect only the information that is needed to find out whether the woman is a good fit for the program. Any further information that is required can be obtained during the intake process and in future conversations.

4.4. Supporting Women with Varying Levels of Mental Wellness and/or Substance Use

Most of the skills you have can be used to support women with mental distress. Women who experience emotional or psychological distress also need a listening ear, a nonjudgmental approach, empowerment and information. - Greater London Domestic Violence Project

– Greater London Domestic Violence Project[xxiv]

As anti-violence advocates, we need to think about the ways we interact with all women to ensure we are not mirroring dynamics of power and control that women have experienced as disempowering in other relationships. In this section we cover some of the things you might think about, and practical tips for supporting women with varying levels of mental wellness and/or substance use.

4.4.1. Safety Planning and Harm Reduction

The philosophy of harm reduction requires health care/service provid-

ers to set aside their judgements in order to address problems and crises on the client's terms. The worker becomes a consultant who assesses the client's needs, provides information and options, and allows the client to set her/his own goals.

– Amy Hill, Domestic Violence Prevention Coordinator, Contra Costa County Health Services[xxv]

Harm reduction is often thought of only in terms of substance use—specifically, safer substance use practices. However, Transition Housing programs already engage in broader harm reduction practices by providing safe shelter, food and support for women who have experienced violence, whether or not they ultimately decide to leave their abuser. Women who have experienced violence go through a great deal of physical and emotional pain, stress, anxiety and exhaustion, and we find ways to support women to ease these impacts. This larger strategy of harm reduction is integral to the work we do, because it lets women know that they have support no matter what.

We can use harm reduction principles in our conversations with women, not just around mental wellness and/or substance use, but to find out what we can do to support her to feel safer—including discussions about:

- The various stressors she experiences, not just the violence.
- How has she managed to cope with the violence and other stressors?
- How does she feel about how she has been coping? How has her coping helped her? How has it not been helpful? Is she interested in exploring other ways to cope?
- How does she find ways to take care of herself? What gets in the way of this, sometimes? How can you support her in this?

Areas of discussion specifically around mental wellness and/or substance use:

- How does she feel about her mental wellness and/or substance use? Does it affect her life?
- Does she see her mental wellness and/or substance use connected to her experiences with violence?
  - Does her partner use substance use as a means to control her (control her behaviour or her supply)? Does the abuser use substance use as an excuse for violence?
- Does she think her mental wellness and/or substance use sometimes gets in the way of her safety?
  - If yes, how so, or in what areas? How has she planned for safety, or what has she done to stay safer before? How can you help support her in feeling safer?
  - Can she use substances with safer people or in safer settings? Is there someone she can connect with while she is using substances, if she finds herself at risk of violence?
- Does she know what types of situations might ”trigger” stressors to her mental wellness and/or substance use? What has she done/can she do to deal with those triggers? How can you support her in this?
- Is she interested in making any changes in her levels of mental wellness and/or substance use? If so, does she know what changes she would like to make? Does she have any ideas about how she might make changes? How can you support her in this?
- Is she interested in talking about her mental wellness and/or substance use? Is there anyone else she thinks she might benefit from talking to?
- Has she accessed supports for mental wellness and/or substance use before/in the past? What does/has she found helpful? What has not been helpful? How can you support her to find support that she is comfortable with?

Remember—no one expects you to be a drug and alcohol expert—you just need to be able and willing to have conversations with women about their substance use and relate these conversations to the risks women are exposed to, their safety and ongoing physical, mental, emotional and spiritual needs

– Tessa Parkes, Freedom From Violence toolkit[xxvi]

Women may have a difficult time focussing or concentrating while talking with you about how to stay safe. This may or may not be related to mental wellness and/or substance use. You may find you need to repeat things, or strategize over time rather than in one session. Other strategies you might use with women who are having difficulty focusing include:

- Ask if she would like to take notes or write down what she thought was important—help her plan for where she will put the notes, or how she will remember them.
- Review the most important points with her over time.
- Ask her what you can do to help her stay "present."
- Ask if there is a different way you could talk about safety that might be better for her.

Women with varying levels of mental wellness and/or substance use may benefit from planning for situations where they may be unable (or may be seen as unable) to make decisions for themselves. How will they take care of themselves and/or their children? For ideas about how to make formal and legal plans with women, see "The Representation Agreement Act, Ulysses Agreements and Advance Directives" in Section 2 of the Ending Violence Association of BC Freedom From Violence toolkit, available at **www.endingviolence.org/node/459**.

4.4.2. Working at a Woman's Pace

Women-centred services need to go at a pace the woman we are supporting is comfortable with. Each woman we see will have different needs, and may or may not wish to engage with the programming and services we can offer. We can present a woman with options, but it is up to her to determine the path and speed she wants to walk.

We all know the length of stay limitations for women and their children in Transition Housing programs. Some programs regularly extend women's and children's stays, while others will only do so under extreme and compelling circumstances. Whatever the case, women have a very limited period of time within which to entirely reorganize their lives and those of their children's, if they are not returning home. This limited period of time can cause staff to work with women in ways which encourage them to develop plans quickly. Our work with women who have stayed in Transition Housing programs indicates that such an approach can be problematic and detrimental for women.

Women-centred practices recognize that we all react and respond differently to crisis. When in crisis, some of us quickly move into action to control and manage our circumstances. Some of us fear that if we slow down, we might become overwhelmed by our emotions, and that our fear, sense of loss and grief and many other emotions will leave us feeling incapable of doing what we want to do. On the other hand, in crisis, many of us need to be able to stop "moving" to "take stock" and to think about what it is we

want and need to do next. In addition, some women who come to Transition Housing programs have injuries and/or have not had adequate sleep and/or nutrition, and are in dire need of rest in order to be able to get their bearings. Some women simply need a break (respite) from their abusers' violence, and to come up with plans (which may or may not involve returning to the abuser) after a break. As women-centred service providers it is our responsibility to take the lead from the women we are working with, and to recognize that "support" will look different to each woman we meet.

4.4.3. Supporting Women with Children

[Y]ou get condemned. Just because you use and have addiction problems doesn't mean you can't love your baby and can't look after them. I mean, I put myself right between that man and my kid many at a time. …. Your baby is behind you. You know, it doesn't matter if he killed you, you will do anything.

– *Woman in Reducing Barriers Focus Group*

Fear of child apprehension prevents women from talking about how experiences of violence have affected them. These fears are well-founded as many people see women with varying levels of mental wellness and/or substance use as incapable of parenting, let alone parenting well. Changes in levels of mental wellness and/or substance use do not make a woman a bad parent and are not themselves reasons for Ministry of Children and Family Development involvement. In fact, most women prioritize their children's safety, even over their own. And having her child apprehended by children's services can further negatively affect a woman's levels of mental wellness and/or substance use.

Women, anti-violence advocates and researchers are finding that one of the more effective ways to protect and support children, is to protect and support the women who are their caretakers.[xxvii] Provide her with a safe, open environment where she can openly talk about the effects of violence on her life. Help her plan for how she can support her children if she is experiencing violence or varying levels of mental wellness and/or substance use—is there someone who can watch the children in the Transition Housing program when she needs some time for herself?

Find out what you can do to support a woman in her parenting:

- How is she feeling about things with her children?
- What supports does she have in place for her parenting?
- What might help her in her parenting? Is there anything the Transitional Housing pro-gram can do to support her?

Support the youth or child by listening to them and finding out how you can support them. You may want to talk to the mother and youth or child to see if they would be interested in accessing a local Children Who Witness Abuse program. See **www.bcsth.ca** for program details.

If you genuinely feel that the woman is unable to care for her children safely or is neglecting or abusing her child, follow your programs' policies, procedures and practices for engaging with the Ministry of Children and Family Development. Wherever possible, speak to the woman first and talk about your concerns for her children/youth and about your requirement to involve a Child Welfare agency. Encourage her to make contact her-

self, and make sure she knows that you will help and support her through the process if she wants you to.

4.4.4. Respectfully Supporting Women

Sarah Payne and Dana Clifford

Sarah Payne has worked in the area of perinatal substance use for over 15 years. She began working at Sheway as a midwife, and then became the Senior Practice Leader at BC Women's Hospital where she was instrumental in establishing Fir Square Combined Care Unit, a dedicated unit for pregnant, substance-using women and their infants. Sarah is an original member of the Faculty of PRIMA (Pregnancy Related Issues in the Management of Addictions), a national group of professionals who work with women, pregnancy and substance use. At the time of writing this work, she was the coordinator of Sheway.

Dana Clifford has worked in the addictions field since 1984. She has a Bachelors Degree in Psy-chology and is a Registered Psychiatric Nurse. Dana has worked in withdrawal management, outpatient treatment and day programs for co-occurring disorders, and has worked at Sheway for the last 16 years. Over this time she has worked with clients who face multiple challenges in life. Through trial and error, she has developed a way of working with women in a respectful manner which encourages empowerment and allows them to explore positive lifestyle changes.

It is so important for all of us who work with women with mental health and addiction issues, to become aware of our own beliefs, thoughts, feelings and fears about these issues. Are there myths we still believe in? Are there personal/family experiences that may have influenced our feelings and beliefs? Do we feel pessimistic, and believe that people cannot change their lives? We need to be very clear about what is "ours" and what we bring, before we work with women.

For example, what does someone having a bipolar disorder diagnosis mean to you? It used to be called manic depression. If someone tells us she has this diagnosis, ask her to talk about it:

- What does it mean to her?
- How would I, as a staff person, know that she might be experiencing symptoms?
- How would she like me to respond to her if I saw any of these symptoms? Often women are very concrete about their symptoms and how they manifest, as well as what is the most ef-fective intervention.

Make her the expert:— She is the expert about her own issues; allow her, to teach you.

Treat the symptoms: If she is anxious, get her to breathe deeply; talk her down, and walk and talk with her. Don't focus on what is causing her anxiety; help her deal with the symptoms of that anxiety.

Assume an overlap of issues: It is rare that one issue presents in isolation. There is often an underlying trauma issue for both substance use and mental illness. If a woman identifies with one of those—say, addiction—they may not feel comfortable talking about their mental health problems. It may be an old diagnosis that has followed her and she really doesn't recognize in herself. Be aware that some women may use alcohol or other drugs to self medicate mental health symptoms. When they stop or decrease their substance use there may be an increase in symptoms. This could also be compounded by withdrawal, as this often presents as mental health symptoms.

Always have an open door: When in doubt, give her the benefit of the doubt. Look at the person rather than at the diagnosis, and be curious about her life and herself, rather than the labels. Many women collect diagnoses throughout their lifespan without understanding what these labels mean, and just accept them.

Be gender informed: So many gender issues are invisible. Rather than thinking, "What is wrong with this woman?" ask yourself, "What happened to this woman?" This opens the door for empathy rather than judgement.

Our clients need to know that whatever they do or don't do, they are always welcome and will always receive service.

<u>Setting Boundaries</u>

Boundaries regarding behaviour are needed.

Anger is a normal human emotion, but the learned behaviour resulting from anger can be dysfunctional. Yelling, or acting that anger out, is not acceptable in a group setting. Letting someone know that certain behaviours are unacceptable, but that she is welcome to come back when she can behave without causing stress to others, is very reconfirming for her. Remember: when setting standards on what is acceptable behaviour, what is normal to one person may not be normal to others. Some people may be accustomed to loud arguing and even shouting in a friendly argument. For others, shouting may have pre-empted violence in their lives, and this can be very traumatizing.

<u>De-escalation When Someone is Upset or Angry</u>

Focus on the expression of anger:

- "It's OK for you to be angry, but you can't act it out."
- "Right now you look ready to blow your top—do you need a place to calm down?"

Ask what she needs, to regain calm and control.

The staff member needs to maintain calm and be in control themselves, to role model this behaviour. If you feel yourself escalating, state: "I need to take some time out, I feel myself getting angry," and leave.

Express that anger is normal, that it is good to feel angry. You could say: "I would expect you to be angry considering the circumstances. If you would like to talk about what you are angry about, I will listen."

Remember that some people use anger as a way to keep others away, as it masks underlying vulnerability. Be aware of this. Anger may be a secondary emotion which they have learned to use to keep them safe. As a professional, we need to focus on the underlying cause.

It is important not to take things personally. This can be very hard to do. We may have worked long and hard with a woman, and poured a great deal of energy into our relationship with her. To have her project her anger at you and/or dismiss you is difficult. Remember: IT ISN'T ABOUT YOU! It is hard to believe this sometimes, but it is true!

It would be helpful to have a colleague or supervisor to debrief with, to help you understand where the negative behaviour comes from. Our curiosity about a person at the outset would help with this. So many women have no control over their lives; they may be under the gaze of social services, or have been controlled by their partners, or are being controlled by a drug. Some women only know how to respond to their fears and vulnerability by pushing back.

Working with Unpredictable, Potentially Dangerous Behaviour

Scenario: A client has psychosis, a huge trauma history and is actively using substances. She is in the transition house, and is hearing voices. She starts yelling and screaming at her voices, and yelling at a staff member sitting across the room to "get out of my personal space."

Try to distract her by bringing her back to the present:

- Remind her that this setting needs to be safe for everyone.
- Ask her what she needs to make her feel safe.
- Ask her to not speak to you aggressively, for example, "Please don't yell at me."
- Ask her who she is talking to (regarding her voices).
- If you feel safe, offer to take her outside.

Know Your Local Resources

There are times when an ambulance needs to be called. What are your local resources? In Vancouver we can call Mental Health Emergency Services or Car 87, a service with a police officer and a psychiatric nurse who do outreach and provide emergency psychiatric assessments in the community.

We can describe what is happening and ask for advice and support. What are your local resources? Can you set up a contact with your local mental health team to provide this type of service to you?

If someone is truly out of control, call 911 or an ambulance. Remember to trust your gut instinct and err on the side of caution. Remember that your safety is of utmost importance. Develop a safety plan with the staff members, for example, "If I say a certain code word, you need to call 911."

Containment

If someone has been triggered and is experiencing flashbacks of past trauma, or is dissociating, it is important to try to help them get grounded. Some effective grounding or containment skills include distracting the person from the intrusive memory:

- Lead her into deep breathing by instructing the person to breathe slowly in through her nose and out through her mouth. Use a simple statement like "You are safe now." If the woman is hyperventilating, have her breathe into a paper bag.
- Have her place both feet on the ground, and ask her to focus on the present. Use a state-ment like "Tell me three things you can see, then three things you can hear, then three things you can feel." Avoid using the sense of smell, as this often can trigger more traumatic events. Keep your voice calm and slow.
- Ask her to make a list of/say out loud, what her favourite TV shows, books or foods are, over and over again, until the mental images fade.
- Does she have a safety mantra, for example "I am safe and in a safe place," or "That was then, I am safe now."
- Encourage the woman to find one or more containment skills she can use to help herself deal with the flashbacks or dissociation. She will need to practice them when she is not in an anxious state, for them to work most effectively when she needs it. For example, she will need to practice doing the deep breathing exercises once or more a day so that it comes more naturally when she needs to use it.

[W]hen a person has both active substance abuse and PTSD [Post-Traumatic Stress Disorder], the most urgent clinical need is to establish safety.

– Lisa Najavits[xxviii]

4.4.5. Working with Women Who Are Distressed

Women with severe mental health issues who experience domestic violence deserve and need support from services as much as, or more than, any other woman. – Women's Aid Federation of England[xxix]

According to the Greater London Domestic Violence Project, experiences of violence are the most common cause of depression and other mental wellness concerns.[xxx] In light of this, some people believe that mental wellness symptoms could more accurately be described as responses to violence.[xxxi] Still, it is important not to make assumptions about where a woman's emotions or behaviours are coming from. It is to be expected that women who have experienced violence may feel angry, upset, anxious or generally distressed, independent of their levels of mental wellness and/or substance use. Aside from the violence from her abuser, she may have ongoing experiences of systemic forms of oppression or discrimination related to her sex, ethnicity, culture, sexual orientation, ability or income. As such, a woman's sadness, anger or anxiety should be taken in context and not automatically attributed to her levels of mental wellness and/or substance use.

Women experiencing domestic violence are more vulnerable to severe and lasting post-traumatic stress reactions, especially those who remain in ongoing danger, experience multiple incidents of abuse and secondary victimisation through negative reactions from others.

– Greater London Domestic Violence Project[xxxii]

Due to service time limits and limited staffing, Transition Housing programs do not have a great deal of time with women. The time we do have is often spent advocating for and supporting women as they navigate criminal justice, immigration, income assistance, child welfare and other systems. Transition Housing program staff just do not have the one-on-one time with women that, for example, counsellors have. Aside from this, women may not be ready to begin processing the violence they have experienced. Our role, then, is to support women by providing a safe place for them to begin to identify options, think about how they are coping with the violence and to connect with counsellors or programming that they feel would be beneficial.

Just by providing safe shelter and women-centred, anti-oppressive, strengths-based supports, Transition Housing program workers may be helping women's levels of mental wellness and/or substance use. For example, researchers in BC spoke to 74 women who used substances as they entered Transition Housing programs, and again three months after, when the women were living in the community. During the second interview, women reported significant reductions in their substance use (for alcohol and stimulants, but not for tobacco or depressants) and felt less concerned about their levels of substance use. ***These findings were the same***

whether women received interventions specifically for their substance use or not. The researchers believed that the women's stay in Transition Housing programs helped reduce stressors related to physical safety, mental wellness, housing, legal and other systemic issues, which in turn lead to less substance use.[xxxiii] Still, although we can help to reduce stressors, women may continue to experience feelings of anxiety, sadness, anger and other mental wellness responses. We have provided some information below on how you might support women who are in distress.

Many women do have too much stress and anxiety in their lives. They may be taking care of children, elderly parents, husbands and jobs, with very little assistance. Women often have no time to look after themselves, physically or emotionally. They are more likely than men to be living in poverty as single par-ents or as seniors. Yet these are social and economic problems that will not be solved by giving pills to women. The real solution is to provide women with ser-vices and community support.

– Frances Kirson, Community Researcher[xxxiv]

Supporting Women Who Are Angry

Some of us can become angry when we are afraid, and women residing in Transition Housing programs are no different. Anger is a much more powerful emotion than fear, but most women have been socialized not to react in angry or aggressive ways. For those who do, it is critically important under such circumstances for workers to behave in ways that de-escalate rather than escalate the situation.

A woman may have found anger to be a form of resistance to violence from her abuser, or to judgements and generally negative interactions with people and/or service providers. We might think about how anger may be a normal reaction to a woman's circumstances and how it may be helping her in some way:

- Talk with the woman in a respectful tone. Try not to let your own anxiety about the situation make you sound authoritative or condescending.
- Ensure that your body language is non-confrontational. For example, if you are standing, sit down, if at all possible.
- If the resident is yelling at you, let her know that you are interested in what she has to tell you, but that you cannot concentrate on what she is saying when she is yelling.
- Ask the resident if you can return to the conversation after a short break.

Supporting Women Who Are Fearful/ Anxious or Who Dissociate

<u>Anxiety and Fear</u>

Women who are experiencing or who have experienced violence, may have feelings of anxiety and/or fear. Women are at an increased risk of violence when they try to leave the abuser or when they seek support around violence, mental wellness and/or substance use, so their feelings of fear are well placed. Feelings of anxiety may continue because a woman is still in real danger, or because her levels of anxiety and fear have been more permanently affected as a woman adapts to the continued threats to her safety.

It may be difficult for the woman, and for us, to differentiate between reasonable fear of current threats of violence, and anxiety and fear related to past experiences of violence.

Still, anxiety and fear are normal, adaptive responses to violence and it is important that we see them this way. It is up to the woman to determine whether or not she is still at risk of violence. Our role is to provide options and information which may help her feel or stay safer from the risks of violence she perceives.

Fear of Things/Situations That May Not be Real

If a woman is fearful of situations or people you are not sure are real, some anti-violence advocates suggest neither confirming nor denying the woman's beliefs. Focus on how she is managing to stay safe and how you can support her in that process, making suggestions to help her feel safe now.

Dissociation

SSome women dissociate, or avoid feelings that are too intense for them, by avoiding or shutting thoughts and feelings out. This is one of many defense mechanisms our bodies engage in when we feel unsafe. For example, a woman may feel as if she is watching herself or the situation she is in from outside of her body, may feel completely numb to her feelings and emotions, or create alternate identities to cope with violence. A woman may not remember what happened during their period of dissociation. Dissociation can help a woman feel safe in situations where she is not, and so may be a strategy used when she is experiencing violence. It may also put her at greater risk of violence, if she is unaware of her surroundings. It is up to her to decide whether this is an effective coping mechanism.

Dissociation can be considered to be a highly creative survival technique, because it allows an individual to endure extremely challenging psychological circumstances while preserving some areas of healthy functioning. – *Tessa Parkes, Freedom from Violence Toolkit*[xxxv]

Grounding

For some women, if dissociative or avoidance strategies stop working, flashbacks or more feelings of anxiety and fear may emerge. If a woman seems to be feeling especially anxious or fearful, or if she gets lost in her thoughts about the violence or threats of violence, it may be helpful to have her connect to the present moment or "ground" herself. Grounding may also be useful for women who are cutting back on substances, or who are angry or sad.

To help a woman get "grounded," ask her to use one or more of her five senses to focus on what she is seeing, hearing, tasting, smelling or touching at the present moment, to help her stay in the "now:"

- Look at, recognize and name objects in the room.
- Listen for sounds happening right now, and name them.
- Chew a piece of gum or drink/taste something that is associated with comfort.
- Carry and use scents (lotions, candles, perfume) that you find de-stressing, that can help keep you in the present.
- Feel the texture of your clothes or the chair you are sitting on—what do they feel like?

Connecting to the present moment and the things around a woman may help her realize that, right now, she is safe. Other things to keep in mind when supporting women who have experienced violence:

- Be aware of the wording you use. For example, the word "relax" could trigger

memo-ries of sexual abuse.

- Asking her to close her eyes and/or go through a guided breathing exercise could make her more anxious, or lead to dissociation.
- The goal is to distract her by taking away her focus from the feelings or emotions, so that she realizes she is safe in this moment.

For more on grounding:

- Lori Haskell's *First Stage Trauma Treatment: A guide for Mental Health Professionals Working with Women.*
- Lisa Najavits, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.*
- Elizabeth Vermilyea, *Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress.*

Some suggestions for supporting women who are experiencing anxiety (from The Greater London Domestic Violence Project):

- *Provide information and/or resources about anxiety, and the link to ex-periences of violence.*
- *Help her think about how she is safe in this moment.*
- *Ask the woman to focus on her breathing, for example, by breathing out slowly when she is feeling anxious.*[xxxvi]

Supporting Women who are Sad/Depressed

Women who have experienced violence, especially women who have experienced violence recently or are still at risk of violence, are especially likely to feel sadness and depression. Aside from physical violence, a woman may have been experiencing psychological assaults including criticism and insults that can affect thoughts, moods and emotions. A woman may experience shame and guilt because of the violence itself, as well as her levels of mental wellness and/or substance use. As always, ask women who are sad or depressed how you can support them, and come up with strategies together about how she might lift her mood. Ideas might include. Ideas might include:

- Help her to recognize and focus on her strengths, small achievements and/or successes, including her ability to stay alive and cope with the violence.
- Help her focus on doing a little at a time, rather than on the larger number of tasks that may seem insurmountable.
- Help her to alternate things that feel like work, with things that help her feel better.[xxxvii]

Supporting Women who Self-Harm

A person does not heal from needing [self-harm], nor from trauma itself, by attempts to eliminate the coping mechanisms which allow her to survive her history. Healing is a process of growth in which, by increasing understanding of the impact and repercussions of trauma, the survivor begins to expand her perspective and options for making choices. – Women, Co-Occurring Disorders and Violence Study[xxxviii]

Self harming behaviours are more common than most people think. People of various backgrounds and ages engage in forms of self harm (cutting, burning, punching themselves,

picking their skin, pulling out hair, heavy substance use), but there is a strong connection between women's experiences with violence and the occurrence of self-harm.[xxxix] Although self harming may be confused for attempts to commit suicide, people may actually use self harm as an alternative to suicide. Self-harm may be a way to stop flashbacks, dissociative responses or other intense emotions. Self harm may also help women feel like they can gain control or cope with stress or may be used by women to punish themselves.[xl]

How anti-violence workers can support women who self harm:

- Make it OK to talk about how they are coping with their experiences of violence and other stressors.
- Take a strengths-based approach—avoid negative comments or judgments about how she is coping, and focus on how she has managed to stay alive.
- Ask what she thinks about the self-harm and whether she sees it as connected to her experiences of violence. If she is interested in exploring these links, provide her with op-tions about how she might do so (for example, within the Transition Housing, Stopping the Violence or other anti-violence programs, or with mental wellness service provid-ers).
- Facilitate access to medical support if she needs it, and do so in a way that lets her know she should not be ashamed or feel bad about herself.
- Try not to focus on/assume that stopping self-harm is the only goal.

Supporting Women Contemplating Suicide

Women who experience violence are more likely to attempt suicide than women who have not.[xli] Suicidal ideation may be seen as a choice for women who feel they have little control or options. In other words, suicidal thinking is actually a form of regaining control—by being able to choose to live or to die. For some women, suicide may seem like the only way get away from their abuser and to end the violence. Your program should have policies/plans in place for how to respond if a woman attempts to/does suicide. Even if a woman is in severe distress, it is important to find ways of supporting her that will not be experienced as disempowering or shaming.

If you suspect a woman is suicidal:

- Make sure she knows about any confidentiality limits, or requirements, that you tell some-one else.
- Let her know who you will tell, and involve her in any planning.
- Connect with your manager and plan for how to proceed.

Other ways to support the woman:

- Ask her directly if she is considering suicide.
- Ask her if she sees a difference between wanting an end from the violence, and ending her life.
- Validate her feelings, for example, that wanting an end to the violence and accompanying feelings is normal.
- Let her know that you care about her safety and that she has a right not to experience vi-olence.
- Ask her what you can do, or what she might do, when she is feeling suicidal—are there people she would be interested in talking to? How can you support her? Make a plan with her for how she might get through the next few hours or days.

If a woman attempts suicide, respond as you would any medical emergency: stay calm and seek medical assistance. A woman needs support more than ever at this time; do your best

to support her and to connect her with others who will be supportive. Keep in mind that some women cannot think about carrying on, regardless of what you do, and they may make the choice not to. You can be as supportive as possible, but suicide is not a choice you are responsible for.

In an Emergency

1-800-SUICIDE (784-2433)
Operated by Crisis Centre, a provincial non-profit organization. The province-wide toll-free phone line operates 24 hours a day, 7 days a week for people in distress. The Crisis Centre also offers professional development workshops across BC at a reduced rate for non-profits. See **www.crisiscentre.bc.ca** for more information.

310-6789
Connects people in distress to a BC crisis line without a wait or busy signal 24 hours a day. Do not add any area code.

A Note on Suicide Contracts

Some programs use suicide contracts, where women sign an agreement promising that they will not harm themselves. These may be helpful for some women, but others simply may not be able to keep this promise. If a woman is unable to keep the promise, she may feel she has let you down, which can make her feel even worse. Be sure to ask her how she feels you can support her best before using any contracts.

To learn more about suicide, visit **www.suicideprevention.ca**.

For tools which may help your program to better recognize, assess and respond to women who are suicidal, visit the Ministry of Children and Family Development's suicide prevention website at **www.mcf.gov.bc.ca/suicide_prevention/at_a_glance.htm**.

For a factsheet for women on coping with mental wellness crises, visit HeretoHelp, a BC Partners for Mental Health and Addictions Information website at **www.heretohelp.bc.ca/publications/factsheets/emergencies**

4.4.6. Working with Women Who Use Substances

We can try to measure risks, but safety is not a commodity which can be easily quantified. But we can work towards safe-r and safe-enough ways of being....My aim is not to hold women responsible for the violence of men, but to resource them to be as safe as they can be. What gets measured when young women leave this program is their level of use of drugs and alcohol. But there are immeasurable changes promoting safe-r ways of being that go unnoticed in all of our work. – *Vikki Reynolds, Social justice activist and therapist*[xlii]

It's easy to see why it is important that women have access to Transition Housing programs, if we keep in mind that substance use may be a woman's way of coping with her experiences of violence. Providing women with a safe, supportive environment may help reduce her anxiety and stress, and could also help her feel like she needs to cope with less. Still, for safety concerns, some Transition Housing program workers are hesitant to have women who use substances in their programs. These concerns usually centre on fear that substances or substance use supplies will get into the wrong hands (for

example, in the hands of children); or on fear of "triggering" other women. In this section we encourage you to think more about how to prevent these concerns from happening in the first place, and how to address them head on when they do come up. Ultimately, it is important we find ways of working that enable the women most marginalized from our services to access our support.

Supporting Women to Keep Substances Safe

Transition Housing staff are sometimes concerned about women bringing substances (whether prescribed or not) into programs, for fear that children or other women may end up with the substance or that women may overdose. When thinking about how to address these concerns, it is important we keep women-centred principles in mind and work in ways that will not feel oppressive to the women we are supporting.

Providing women with lock boxes where they can keep their valuables and medications is both a safe and women-centred practice. This puts control over a woman's medications in her hands and can help ensure that medications or any other substances/substance use supplies are out of reach of others in the program (if your program does not permit illicit substances on-site, you can state this in your program guidelines or policies). Ensure the lock box/locker is mounted to the wall or bolted to the floor, so it can't be stolen/taken from each room. Having locks on bedroom or suite doors goes further to reduce safety concerns. If you find that women are not using the lock boxes (for example, if you find medication or substance use supplies outside the lock boxes), remind women why you provide the lock boxes and why it is important to use them.

Policies and procedures can direct staff on how to communicate this policy to residents and respectfully ask that any valuables and medications/substances be stored in their locker. With the policy, and when communicating the policy to women, provide a clear rationale for why this is important (for example, that it ensures her things are safe and that substances are safely out of reach of children).

Assisting Women with Prescribed Medications

Staff may worry about women remembering to take their medications. It is important to remember that women have been taking (or not taking) their medications before they came to your program, and are likely capable of continuing to do so. **Women with prescription medications have been viewed as competent to administer their own medication by physicians and pharmacists, and dispensing or monitoring a woman's medications puts your agency at risk of liability.** The BC Pharmacists, Pharmacy Operations and Drug Scheduling Act prohibits anyone who is not licensed as a pharmacist from dispensing a "limited access drug," and your programs' liability insurance may not cover you if an error is made.

Monitoring dosages can be physically harmful to women. For example, if a woman has not been following the suggested dosage and program staff change her dosage, she could be at risk of negative side-effects, including seizures. If you record information in relation to a woman's medications, it may be subject to subpoena and could be used to discredit a woman and/or cast doubt on her ability to parent in court. Most importantly, monitoring of medications can feel controlling to women and such practices contradict a women-centred approach.

Some suggestions for supporting women to take their medication:

- During intake, state that some women have a hard time remembering to take their medica-tion with all the changes going on. Ask her to let you know if she wants any reminders, or if there is anything else you can do to help.
- If she is comfortable enough to talk to you about her medications, find out how you might recognize and support her if she has forgotten to take her medications.
- You may give women the option of keeping their medication in a central, locked place (for example, an office) if she has a difficult time with her medications, but this should be an op-tion, not a requirement.
- In general, you don't need to know about the specifics of each medication. Just know when she needs to take them, how often and if they may interfere with her ability to participate in various things (for example, if she gets nauseous with her medication but has to take it dur-ing the time of dinner preparation, don't have her scheduled for dinner preparation at the time she has to take her medication).

Policies or practices around food availability or locking fridges can also affect women who need to take medications. **Many medications that women take can make them hungry, nauseous or light headed, so access to food at various times is important to them.** Also, some medications can't be taken with food but need to be taken at specific times of day. These times may not coincide with when food is served/ available in your Transition Housing program, so some women may not be able to eat at the times food is available. Having to ask for food can feel controlling for women. Your program should have unrestricted access to food and juice throughout the day, for these reasons.

Substances That Are Not Prescribed

Your Transition Housing program may feel it is necessary to set boundaries around whether substances that are not prescribed can be brought into the Transition Housing program, or where women can use substances. If this is the case, make your policies and procedures known to every woman who enters your program and provide a rationale for why you have set these boundaries. Ask each woman if she thinks the policy will be difficult to follow. If so, strategize around this and try to find solutions where all people in the program (including the woman) feel they are safe and supported.

Searching women's belongings and rooms for substances or other things feels extremely disempowering and controlling to women, and does not reflect women-centred principles. Although women may consent to the searches, they may be doing so under duress if they feel the Transition Housing program is their only option for safety. Searching for and disposing of illegal substances can put women at further risk of violence if they are holding on to the substances for someone else. Asking that women not bring illegal substances into the house or that any substances be safely and securely stored in a lock box—and explaining the reasons behind that practice—is much more empowering, because everyone in the program is acting collectively to create a sense of safety.

The Ontario Association of Interval and Transition Houses has created 'Safe for All, a video about harm reduction in Violence Against Women programming. The video is 30 minutes long and is available on the video section of their website: **www.oaith.ca/resources/videos.html**

Substance Use Supplies

To learn more about harm reduction in regards to substance use, common concerns with harm reduction practices, evidence based practices and how to build a harm reduction strategy for your program see Harm Reduction: A British Columbia Community Guide **www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf**

Lock boxes can provide women with a safe place to store any substance use supplies they may have. Clean needles, pipes and other supplies are not illegal to possess or buy, and storing them in a locked place will ensure they are not accessible to other people in the program, including children. Some programs have a cupboard with clean substance use supplies that women can access when needed. Some of the basic supplies which might benefit women and that your program might consider facilitating access to:

- Sharps containers where women can safely dispose of used needles, whether the needles are used for injecting insulin for women with diabetes, or other substances.
  - These may be stored in locked cupboards or in another secure place where women will not feel they are being monitored or judged when they make use of them.
  - Find out more about considerations when installing sharps containers from the Occupa-tional Health and Safety Agency for Healthcare in BC website at www.ohsah.bc.ca/media/87-FS-Sharps.pdf.
- Clean needles, or information about where women can get clean needles.
- Methadone.
  - Methadone is a chemical alternative to heroin, codeine, morphine or other opioid sub-stances. It is usually taken once a day to reduce cravings for the other substances, and when taken as prescribed, does not produce the ”high” that other substances do. It is relatively safe and has few side effects.
  - Methadone is usually prescribed by a physician and dispensed by a community phar-macist.
  - A woman could be at risk of violence if an abuser knows where she goes to get her me-thadone, so you may want to consider this in your safety planning with women.
  - Some programs make arrangements with their local pharmacist to have them come to the Transition Housing program, or to store numerous days’ worth of a woman’s me-thadone in a fridge on-site.
- Information about substance use, the connections to violence and local resources for women.
  - See the Ending Violence Association of BC Violence, Substance Use and Mental Health: A Peer Approach to Increasing Your Safety workbook for women, created by women, at www.endingviolence.org/files/uploads/PAVEWorkbook.pdf

Connect with your local Health Authority and/or substance use agency to find out more generally about providing substance use supplies and harm reduction practices. Providing these supplies can help ensure that the women, youth and children in your programs are safe.

For information on substance use supplies and harm reduction, see the BC Centre for Disease Control Harm Reducing website at **www.bccdc.ca/prevention/HarmReduction/default.htm**.

For more on safer injecting processes, see Safer Injecting Resources Pack produced by

Kevin Flemen in the UK at
www.kfx.org.uk/resources/nx08.pdf

Supporting Women Who Are Reducing Substance Use

The best thing we can do for a woman is to support her where she is at—to counter the feelings of shame she may have experienced related both to her experiences of violence and to her substance use. We can do this by honouring the woman's strategies to cope with violence and by not pushing her to make changes she is not ready for. **It is up to the woman to decide whether her coping strategies work for her, or if and when it is time to explore other options.**

If a woman indicates she is interested in exploring other ways of coping or reducing her substance use, let her know what you can talk with her about, how you can support her and what other resources are available to her in your community. Try to avoid making assumptions about the changes a woman wants to make. Even if a woman decides she wants to cut back or stop her substance use now, it doesn't mean that will always be what she wants.

Some strategies:

- Ask specifically what changes she feels ready to make.
  - Focus on small changes that can reduce harm, which may be more realistic than trying to stop all substance use altogether.
- Ask her how you can support her in making those changes.
  - What has she found helpful in the past? What was not helpful? What would be helpful now? What would not be helpful?
  - Let her know you are there to listen no matter what she has to say. Making changes can be hard, especially when in crisis, so let her know you are there to listen when she is feeling challenged—whether she makes the changes or not.
- Ask if there are other people/resources she has found useful in the past, or would be in-terested in accessing now.
- If she is interested, provide information about options she may not have thought of.
  - Are there other community resources you know of that she might be interested in?
  - Does she think she requires medical or withdrawal management support?
  - Are there books or other resources she might be interested in?
  - Do you have ideas about how you could support her? Can you help her stay busy when she is having cravings? Can you provide information about some other ways to self-soothe?

See Section 4 Appendix (page 66) for other ideas on how to support women cutting back on substance use.

In general, focus on creating a trusting relationship where a woman can speak openly with you, no matter what. Creating an environment where she has physical and emotional safety can help her shift her attention from staying safe, to taking care of herself (for example, through eating or sleeping), which in itself may help her reduce her substance use.

For more resources on mental wellness and substance use that staff or women who are residents might find useful, including a factsheet on treatment, visit HeretoHelp, a BC Partners for Mental Health and Addictions Information website at **www.heretohelp.bc.ca/publications/factsheets/treatment_su**

Supporting Women Under the Influence of Substances/Medication

It is important not to make assumptions about the cause of a woman's behaviours. As discussed in Section 2, **nodding off, incoherence, slurred speech and other behaviours can be the result of exhaustion, hearing impairments, head injuries and other effects of violence. Even if these behaviours are related to substance use, these are not dangerous or threatening behaviours and therefore do not warrant asking a woman to leave.** Often women who are under the influence of substances are content, because they are engaging in a coping strategy.

Some programs that support women who use substances, ask women who are obviously under the influence of substances to go to their room or another private space. This may be an option if, for example, the woman's behaviour is disruptive or if there are other women in the program cutting back on their substance use. Requesting a woman move to another room must be done in a transparent way so as not to seem as though the woman is being punished for her coping strategy.

When a woman is under the influence of substances, it may not be the best time to engage in conversations about safety planning. **The most important thing is, right now, the woman is safe.** Conversations about how she has stayed safe, and how she may build on those efforts, can wait. Give her time to sleep, to rest and to decide for herself whether she wants to engage in the programming and talk with you about her experiences with violence.

Supporting Women in Withdrawal or Who Have Overdosed

Without medical supervision, it is not wise to advise women to stop their substance use altogether. Withdrawal symptoms can range from mild to severe to life threatening, depending on the substance, the frequency of use and the person. If a woman is considering making a drastic change in her substance use, discuss with her how she might go about doing this safely. Consult with medical or substance use workers if you are unsure of anything.

Your program will want to have policies and procedures in place for medical emergencies in general. Some programs have regular check-ins with women who are at-risk of harm due to mental wellness and/or substance use. For example, staff may knock on women's doors if they have not been seen by any program staff for a set period of time. Whatever your policies and practices, make it clear to women why you are doing what you are doing and how it benefits them.

Keep in mind that many of the symptoms associated with withdrawal and overdose are similar to many of the feelings, emotions and behaviours women may exhibit after experiences of violence (for example, sleepiness or confusion). If you suspect a woman is in medical distress, seek medical attention.

<u>Possible Signs of Withdrawal</u>[xliii]

- Depression.
- Anxiety.
- Irritability.
- Panic attacks.
- Hallucinations.
- Tremors.
- Paranoia.
- Fatigue.
- Flu-like symptoms.

- Sweating.
- Sleep disturbances.
- Headache.
- Weakness.

Possible Signs of Overdose[xliv]

- Very slow breathing (or no breathing at all).
- Cold skin.
- Lips and nails turning blue.
- Throwing up.
- Seizures.
- Chest pains.
- Loss of consciousness.

For a factsheet on overdose, visit HeretoHelp, a BC Partners for Mental Health and Addictions Information website at **www.heretohelp.bc.ca/publications/factsheets/overdose**

4.5. Finding Other Services for Women

There will be times when workers will need to find other services for women, whether a woman is interested in accessing other services in addition to those we are providing, believes that our program is not a good fit, or we find we cannot accommodate a woman in our housing program. Making effective referrals is a crucial part of Transition Housing work. Below we talk about some of the things to think about when finding other services for women.

4.5.1. Making Effective Referrals

If you are unable to provide sufficient support to a woman, or if a woman indicates she would be interested in accessing support from mental wellness and/or substance use sectors (or others), find out what other services or supports would be helpful for her:

- What areas of concern are most important to her?
- What supports or services does she think would be helpful right now? What is she not look-ing for?
- Is she accessing any other supports right now? If so, does she feel they are helpful? How could things improve? If not, what has kept her from accessing support?
- What kinds of supports has she found helpful in the past? And unhelpful?

Although many people believe that mental wellness and/or substance use services are residential, there are many non-residential options. In Freedom From Violence: Tools for Woking with Trauma, Mental Health and Substance Use, Tessa Parkes identifies possible support service options for mental wellness and substance use.[xlv]

Mental wellness support services:

- Peer groups.
- Mental wellness response teams.
- Social Workers.
- Clinical Counsellors.
- Psychologists.
- Psychiatrists.
- General Practitioners/Doctors.

Substance use support services:

- Detox or withdrawal management.
- Daytox or stabilization groups.
- Outpatient treatment.
- Intensive non-residential treatment.
- Residential treatment.
- Supportive recovery services.
- Pregnancy support services.
- Street outreach programs.
- Needle exchange programs.
- Methadone treatment.
- Safe, supported housing.
- Integrated trauma and substance use treatment programs.

Make connections with local resources—find out about their services and philosophies, and whether they have an understanding of the connections between violence against women, mental wellness and/or substance use. Find out whether the other service providers would be interested in learning about the effects of violence on women. Your program and/or agency may provide the training, or you may find another anti-violence agency that can facilitate training. For example, the Woman Abuse Response Program at BC Women's Hospital & Health Centre provide Building Bridges workshops for the health, mental wellness, substance use, ant-violence, justice and child welfare sectors in BC that explore how violence, mental wellness and/or substance use "intersect to create risks to women's health and safety and add barriers to accessing services," and how service providers can support women.

The Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services suggest anti-violence advocates take the following into consideration when making a referral:[xlvi]

- The first concern should be safety. Will the assessment referral agency place the woman or children at risk of further harm? What strategies can be used to ensure safety?
- What assurance and/or support does the woman need to follow through with the refer-ral? Women who have experienced violence may not be comfortable with the idea of talking with someone they do not know about their concerns, or may fear what will re-sult from going to the referral agency. What concerns does the woman have about the referral service? Can they be addressed, and how?
- What information does the woman need to follow through with the referral (for exam-ple, where do they go, who they will see and how will they get there)?
- What support does the woman need to keep the appointment? Is transportation or childcare needed? Are there other barriers?
- Women who have experienced violence should not be referred to programs that require couples or conjoint counselling.
- Many service providers do outreach: they will visit the woman. If outreach will place the woman at risk, it is important to convey that information to the provider.

In terms of resources, the mental wellness and substance use sectors face some of the same challenges as the Transitional Housing sector. You may experience challenges connecting women to some services, especially if they are not seen as a clear danger to themselves or others. This is why it is important to find out about the various options available to women—if they are unable to access one, provide them with another option. Having ongoing conversations about the challenges your local mental wellness and/or substance use services are experiencing, and how best to refer women, can help you as you try to connect the women to resources they identify a need for. See Section 4 Appendix (page 67) for a sample referral pathway.

For mental wellness or substance use resources and referral in or near your community, please consult with your local Health Authority. See the Reducing Barriers Appendix (page 11) for a more comprehensive list of resources and referral agencies, including information for each Health Authority.

Provincial Mental Wellness Resources/Referrals
1-800-661-2121 /604-669-7600
Taped information on provincial mental

health programs as well as symptoms, causes, treatment, support groups and publications.

Provincial Substance Use Resources/Referrals
1-800-663-1441 / 604-660-9382
www.health.gov.bc.ca/navigation/1-800.html#alcohol

Other Resources
www.bcmhas.ca
BC Mental Health & Addiction Services website.

811
www.healthlinkbc.ca
HealthLink BC offers free, non-emergency health information. You can also speak with a nurse about symptoms, or to a pharmacist about medication.

4.5.2. Requiring a Woman to Leave

When the women leave Crabtree Corner Housing services, our relationship with them does not necessarily end. We may not hear from them for some time, but some return, either to say hello to the staff or to access the services…. This continued relationship is an indication that we have gained a woman's trust. This is the most important thing we can achieve and is a large measure of the success of our program.
– Advocate, Vancouver YWCA Crabtree Corner[xlvii]

As anti-violence programs, our goal is to provide all women with a safe environment free from violence. **Mental wellness and/or substance use should not be a reason, in and of themselves, for asking women to leave your program.** Our focus should be on behaviours, and problematic behaviours may come from any resident of our program—not just women with varying levels of mental wellness and/or substance use. For example, violence and verbal abuse from a resident would be considered problematic behaviours in most cases. Unless the behaviour is overtly dangerous and likely to continue, it works best to talk with the woman about her behaviour, what might have precipitated it and whether she is able to make changes to the behaviour. Ask her about what you can do to help. **Most often, when women feel respected, supported and not negatively judged, they will try to adjust their behaviour.**

There will, of course, be behaviours that cannot be accommodated in a communal living situation, and as a result, times you will be required to ask women to leave the Transition Housing program. It is important to remember that you do not want to say things or act in ways that could damage your relationship and rapport with a woman whose behaviour cannot be accommodated. **Your relationship with her is the single most important factor in ensuring she has access to the support and resources she needs.** Women who access anti-violence services but do not feel respected or supported may not reach out again in the future. In addition, how quickly women recover from experiences of violence is very much connected to how they are treated by the service they reach out to.

If a woman's behaviour cannot be accommodated in the Transition Housing program, let her know that the problem is the limitations of the program, rather than her own limitations, and that communal living requires adjustments that many women cannot make. Tell the woman that you will do all that you can to ensure that she gets access to the

services she needs and that you are there to support her through the transition to another service. Be sure to tell her that although she cannot be accommodated at this time, you hope that if she should need you in the future she will not hesitate to get in touch.

Despite our best efforts to support the women we must ask to leave, doing so will not always go as we hope and plan. Women may, understandably, become angry or upset. Find ways to de-escalate the situation should it arise, and to let the woman know you want to hear her and support her however you can. See "Supporting Women Who Are Angry" in Section 4.4.5 for more details.

4.6. Creating Support Networks

The Promising Principles require us to find innovative ways of working and collaborating to ensure women have the support they need. Part of that involves partnering with other service providers, but women in the Reducing Barriers Focus Groups told us that having space to connect with one another was important as well. Women felt they benefited from sharing and learning from other women who had similar experiences. Similarly, it is important for workers in the Violence Against Women (VAW) field to find ways to connect with others, feel supported, and to share, learn and grow.

4.6.1. Creating Peer Support Networks

People connect with people, that is what is at the core of why you are the way you are. We need to have more groups or whatever; places where people can go to work on themselves and have improvement, not just find you a home and there you go

– *Woman, Reducing Barriers Focus Group*

Many women benefit from connecting with one another around the effects of violence, so that they have the opportunity to build on one another's strengths and abilities to survive. Groups, whether formal or informal, may help women to better understand the connections between violence and mental wellness and/or substance use, which can normalize the responses and reduce feelings of isolation and shame often felt by women fleeing violence. Consult with the women in your program to learn what they would find most useful.

Just a lot more support groups. You know, not formal, 'cause that just doesn't work for some people—or a lot of people, I am sure. But you know, casual and laid back, where they can get information on why they are doing what they are doing—you know, who can help, right? Names and numbers, not just "Stay here and do what we tell you to do, and we'll help you"—'cause that doesn't work all the time. – *Woman, Reducing Barriers Focus Group*

Learn about women-only group programs in your area that acknowledge the role that experiences of violence can have on mental wellness and/or substance use, or consider facilitating a group for women out of your own agency. Be aware that many existing programs are rooted in the mental wellness and/or substance use fields, and may need some adaptation to further incorporate women-centred, anti-oppressive and harm reduction principles. Whenever drawing from existing programs, make adjustments to ensure the program is meeting the needs of the women

who will access it. Generally, women who have experienced violence often benefit from groups that are specifically designed for women, and that are strengths-based and modelled on empowerment. Keep in mind that some women may not be interested in attending groups or participating in formal programming, so any group work should be optional rather than mandatory.

Sample Groups for Women

In 2011, the Woman Abuse Response Program at BC Women's Hospital & Health Centre piloted low barrier support groups for women who had experienced violence with varying levels of mental wellness and/or substance use, in various communities in BC. The 12-week group model provides women with the opportunity to:

- share their experiences
- explore the connections between violence, mental wellness and/or substance use
- learn new coping skills in a supportive, safe and non-judgmental environment.

The groups are complemented by a self-help workbook for women. The curriculum is set to be finalized in the fall of 2011. See the Making Connections section of the Woman Abuse Response Program's website at www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/default.htm.

The Victoria Women's Sexual Assault Centre has adapted Lisa Najavits' Seeking Safety group model to better fit the needs of the women they work with.[xlviii] Seeking Safety is meant to support women who experience Post Traumatic Stress responses, and who use substances. In Victoria, the groups were co-facilitated by an anti-violence advocate and substance use worker. Women were not required to stop using substances to be a part of the group. Funded by the Vancouver Island Health Authority, the 15-week group program was designed to:

- increase understandings of the connections between violence and substance use
- teach skills for grounding, harm reduction and taking care of one's body
- counter stigma and shame, and increase positive beliefs about oneself.

Other anti-violence advocates have adapted Maxine Harris' Trauma Recovery and Empowerment Model (TREM). In the United States, many of the sites involved in the Women, Co-Occurring Disorders and Violence Study incorporated some form of peer support. For examples see the website at www.wcdvs.com.

There are strengths and drawbacks to every group model. Take some time to think about what these are, and talk with women about what kinds of groups they will benefit most from, as you plan the design of any group. You may want to consider something more informal, like having open drop-ins where women can have a safe place to just hang out, talk or do whatever they feel like. Open drop-ins can also be a good starting place for developing a more formal group.

For considerations about setting up groups, see the Alaska Network on Domestic Violence & Sexual Assault's Support Group Manual: **www.andvsa.org/pubs/Real%20Tools%20Manual_08Version.pdf**. Keep in mind that you may need to make some adjustments to be able to meet women "where they are at."

A Note on 12-Step Groups

Some women may find the use of 12-step groups helpful if they are trying to reduce

their substance use. Others may not. Typically these groups are co-ed, which may not be safe for women who have experienced violence. In addition, the 12-step model was developed by men, for men, and may not feel relevant for some women. The model also emphasizes ”powerlessness” and ”character defects,” and leaves little room for women to explore how their experiences of violence are connected with their substance use. However, there are other ”step” models that women may find useful. For example, Charlotte Kasl has adapted the 12-step program in her book Many Roads, One Journey: Moving Beyond the 12 Steps. Her 16-step empowerment model provides space for exploring beliefs and behaviours within the social context of the patriarchal society we live in, and adopts a strengths-based approach that some see lacking in 12-step models.

Twelve-step programs rarely address the impact of post-traumatic stress disorder and fail to acknowledge the situational nature of substance use. Simply put, violence causes pain and gives rise to feelings that lead to the desire to use drugs and alcohol as a way of alleviating that pain.

– Amy Hill, Domestic Violence Prevention Coordinator, Contra Costa County Health Services[xlix]

4.6.2. Collaborating for Integrated Services

Oh heck, when I went in there abused, I had like two black eyes and stitches…and I did not want to leave that place and come out and see a counsellor. Who wants to wander around with two shiners? I don't want to leave there. I would rather have the counselling done right there.

– Woman, Reducing Barriers Focus Group

Despite knowledge that violence against women, mental wellness and/or substance use intersect, there are few services with philosophies and approaches appropriate for supporting women with overlapping needs. Women benefit when services are reflective and responsive to the connections between these concerns. For example, researchers in the US have found that women who have experienced violence with varying levels of mental wellness and/or substance use have better outcomes when supported through integrated, violence-informed models of service delivery.[l] Women are also helped through practical considerations like providing all ser-vices out of one agency, rather than requiring women to find the transportation and time to go to a number of different agencies for each of her needs to be met. Because of this, finding ways to partner and collaborate with other service providers is important, even if forging relationships can sometimes be challenging.

[T]he anti-violence, feminist, women's community must take a lead on integrating responses to women's experience of violence and the effects of this violence on women's health, mental health and their use of substances.

– Advocates, Battered Women's Support Services[li]

Violence Against Women (VAW), mental wellness and/or substance use services seem to hold contradicting philosophies, with VAW services often based in feminist frameworks

that focus on anti-oppression and empowerment—and health services, especially substance use services, often emphasizing individual accountability. In some cases, mental wellness and/or substance use services may also operate under contradictory frameworks. Although the two sectors are amalgamated in BC on paper, this does not always play out in practice, especially in rural areas where services are few and far between. Yet, more and more mental wellness and/or sub-stance use service providers are working to aknowledge the social determinants of mental wellness and/or substance use. Working with the VAW sector could strengthen those types of analyses.

Aside from philosophical challenges, the VAW, mental wellness and/or substance use sectors have experienced significant changes in the past few years—which make it difficult for internal planning, let alone cross-sector collaboration.

Collaborative connections between service providers in anti-violence and substance use services demonstrate the connections that we hope that women will be able to make and draw on.

– BC Centre of Excellence for Women's Health[lii]

Collaboration can start with building relationships for better referrals, and educating one another through cross-training. These partnerships can evolve; for example, mental wellness and/or substance use workers can visit the Transition Housing program space, or partner with anti-violence advocates in other ways to better support women.

For more on how you might go about establishing collaborative relationships with service pro-viders in the mental wellness and/or substance use sectors, see the Woman Abuse Response Programs' Quick Links for Integration, on their website at **www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/default.htm**.

See the Section 4 Appendix for a sample mutual service linkage agreement from the Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services.

4.6.3. Supporting Staff in Your Program

Physical Well-Being

Some staff may be intimidated about having substance use supplies on-site, possibly related to the risks of HIV and/or Hepatitis strands. These illnesses are not relegated to women who use substances, though. For example, women may contract the viruses if they are forced to have unprotected sex with an abuser. Anyone, resident or staff, can have HIV or Hepatitis strains and staff should always take necessary precautions, whether women who are using substances are in the Transition Housing program, or not. Programs should have clear guidelines on how to handle things like medical emergencies where blood is present; handling needles; sharps containers; or other substance use supplies (for example, by wearing gloves or using tongs).

For more information:
Canadian Centre for Occupational Health and Safety
www.ccohs.ca/oshanswers/diseases/
Public Health Agency of Canada
www.phac-aspc.gc.ca/index-eng.php

For more information about HIV, AIDS and women, contact the Positive Women's Network at **www.pwn.bc.ca**.

Mental and Emotional Well-Being

Counselling in all contexts is often a frontline response to violence, abuses of power, and other acts of oppression. I believe that what is being called "burnout" says a lot more about our society collectively than it says about us as counselors individually. The problem is not in our heads or in ourselves, but in the real world where there is a lack of justice. The people I work alongside don't burn me out and they don't hurt me: they transform me, challenge me and inspire me. We're not "burning out", we're resisting being blown up! What is threatening to blow me up is an inability to work in line with my ethics, and my frustrating failure to personally change social contexts of injustice that clients wrestle with and live in.

– *Vikki Reynolds, Social Justice Activist & Therapist*[liii]

Supporting women who require a lot of support, can be challenging, due in part to the limited resources and staffing that Transition Housing programs work with. Just as women experience barriers to support, you experience a number of barriers in your advocacy work with women. Remember how important it is to continue to link challenges to broader systemic issues, rather than placing blame on the individual women we work with and beside, or placing blame on ourselves as individuals. You and your colleagues will want to find ways to support one another, to problem-solve challenging situations and to debrief.

We will all feel differently about residents that we work with. Some, we will feel very positively about, while others may frustrate or even annoy us. We may even find that we treat residents differently from one another as a result, and often without even being aware of the ways in which we might tend to favour one resident—based on our feelings about them—over another. We may make decisions which, if examined, reflect our assumptions about who is "deserving" and who is not—of our time, community resources and program resources. This can cause or contribute to conflict between residents, and between staff and residents. It conflicts with the overarching goal of women's equality. It may make women who do not get the same treatment as others, feel undeserving or "less than" other residents, and reinforce feelings of inadequacy that can come as a result of living with violence.

I ended up becoming one of those favorite people. I actually had to step up for one lady...and taking one of the counsellors off to the side... You know, it mattered to me what my opinion meant. I had to speak it, otherwise it would dig a nasty hole in my stomach. Man, respect goes a long way in my world.

– *Woman, Reducing Barriers Focus Group*

When you have feelings about a resident that, if given voice, sound something like "she doesn't deserve X" or she is "too demanding" or "whiney" or "aggressive" or "unappreciative" or whatever your feelings might sound like if articulated, ask a co-worker to debrief

with you. Debriefing provides us with a rich learning opportunity to grapple with the day-to-day struggles in our work. In the same way that critically analyzing our practices reveals all kinds of assumptions that may contradict our program goals and values, we can also critically analyze any negative feelings we might have about residents. We can do this on our own, with a co-worker or with the team. Reflecting on our feelings and the sources for our assumptions provides the opportunity to learn about ourselves and the assumptions we make about women that we can modify with the clarity that comes through a process of reflection.

Sometimes when we are experiencing negative feelings about a resident, we "vent" our feelings. This may provide some measure of relief, but unless we challenge ourselves to examine our frustrations—that is, **unless we examine whatever it is that causes our frustration in a way that reflects on us and on broader social systems, instead of on the resident and what it is that is "wrong" with her—we have done little else than to justify our feelings, rather than challenge our feelings, learn, grow and make conscious choices to improve our practices.**

Debriefing involves more than just venting. When a co-worker debriefs your feelings in a non-judgmental and compassionate way, she acknowledges your frustration but moves on to help you to move through your feelings, by asking questions that will help you to reflect on why particular behaviours are problematic for you. For example, if you are feeling like a resident is "unappreciative," ask what an "appreciative" resident might do that a resident you assume isn't appreciative, might do differently. Also, ask yourself why you think a resident ought to show her appreciation. Is she not entitled to our assistance? Could there be some sexist or classist assumptions built into your perceptions? Find points of solidarity with the women you work with and support. Think about what you need, and how you can ensure you have the energy and commitment required to partner with women in anti-violence work.

For more on collective ethics, resistance and burnout, see Vikki Reynold's work at **www.vikkireynolds.ca**.

Reflective Question

What brought you to the Violence Against Women sector? What sustains you in this work?

4.7. Conclusion

We hope that the toolkit has provided you with some insight into the connections between violence, mental wellness and/or substance use, and why it's important to support women who are affected by these intersecting issues. We have identified a number of Promising Principles (Section 3) that will help you as you attempt to partner with women, and form relationships that counter the violence they have experienced. How you implement the Promising Principles into your policies, procedures and practices will depend on the context of your agency and the needs of the woman you serve. Check out the Appendix for other resources and tools that you may find useful in your work.

Above all, remember that mental wellness and/or substance use in and of themselves are not reasons to refuse services to women, or to ask women to leave. For many women, mental wellness and substance use fluctuate

and change as they attempt to cope with violence they have experienced. This work is not easy and can be quite challenging, especially given the limited resources Transition Housing programs work with. We all have work to do to ensure that Transition Housing programs have adequate resources to effectively support women, but we also need to ensure we are supporting women who are often most marginalized the best we can, with what we have.

We encourage you to have discussions with others on staff about "reducing barriers," and to consult with the women accessing your programs about any changes you are considering making. Keep in mind that there may be a group or groups of women who have not been accessing your services, and whose voices have not been represented. Think about who is missing, and consider how you might reach out to and consult with these women as well.

Start with small changes that will shift policy, procedure and practice, and strategize from there about how you can continue to push your work even further towards women-centred, anti-oppressive, relational, harm reduction, holistic and flexible approaches. Build a network of women, service providers and allies who support this type of work, and remember that the staff at BC Society of Transition Houses are in that group and are just a phone call away!

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SECTION 4 - APPENDIX

Frequently Asked Questions in Getting Safe and Sober: Real Tools You Can Use

I want to know how to deal with the manipulations used to avoid substance abuse issues.

'Manipulation' is another word with negative connotations. Let's reframe this statement to read "I want to know how to advocate for women who do not feel safe enough to be open about their substance use." Every day advocates deal with women other systems label as impossible. In our field we understand women make decisions about their safety daily and we recognize dealing with domestic violence is a process. You, as battered women's advocates, have all the skills you need to deal with the 'manipulations' associated with addiction if you understand this manipulation is a survival strategy. Recognize the woman you are working with is in an abusive relationship with a substance that has her in chains no less binding than the oppressive chains a batterer uses to bind a victim. Also, you are not alone. Substance abuse counselors can address the addiction and help you focus on your role which is to provide advocacy. Women facing the dual stigma of both addiction and domestic violence may be reluctant to openly seek help. Generally speaking, women don't routinely self-identify as either addicted or battered unless their safety is assured. Safety includes knowing you are not being labeled or judged. Chemically dependent battered women tell us they benefit most from advocates who:

"Try to make you feel like you aren't the only one. And that somebody else did make it. And someone else has made a life for themselves. They try to make you feel that you're not worthless or useless."

Chemically dependent battered women have little reason to trust. Both their bodies and their partners have let them down. Advocacy based counseling looks different for chemically dependent battered women who may have withdrawal issues, memory distortions and cognitive deficits. Advocacy-based counseling for those impacted by substance abuse and/or addiction may include: Repeating information, providing structure, simplifying goals, advocating for their inclusion in shelters and other victim service programs and understanding the impact of chemicals on safety planning and role identity. Respectful screening for addiction issues that may impact safety involves conveying the message addiction and violence can happen to anyone. Advise women: "Any woman is vulnerable; you are not alone should these problems be facing you." A successful intervention requires internally moving beyond the notion, "Why doesn't she just quit?" or "Why doesn't she just leave?" Questions such as these convey lack of knowledge and failure to understand the complexity of safely ending a relationship with either a substance or an abusive partner.

Honestly discussing sobriety as a safety risk is extremely important. A woman's decision not to stop using immediately or to decline treatment, advocacy or shelter should not be viewed as failure. Recovery is both an option and a process that can take time. Know your resources. Build alliances with substance abuse prevention professionals and treatment providers. You don't need to be a chemical dependency counselor. A chemical dependency counselor can provide treatment when it is safe. Addicts will engage in manipulative behavior because they are terrified they cannot live without their substance. They are in pain and they are scared. If we can accept that manipulation is a reasonable way to address the tyranny of addiction we can acknowledge that manipulation is not about fooling us but about survival. If you feel manipulated, so what! Recognize manipulation is a survival strategy. Be respectful but offer program participants honesty as well as options to honestly get what they want or need when they are ready.

Basic Contact Information for Intake Purposes (Generic)

Name: _____ Date:_____
Address:_____
Preferred Language:_____
Interpreter needed: ____Yes ____No
If we need to contact you, is it safe for you if we phone? ____Yes ___ No
Telephone: _____day _____ evening
To insure your privacy, agency staff will not initiate conversations or contact with you outside of the agency. We leave that to your discretion.

Children (Transition Houses)

Child's name Date of Birth Care Card No. Health Concerns

_____
_____

Name of child/ren not with you at the Transition House_____
Are you the natural mother of the children? ___yes ___no
Does your partner have legal custody of the children? ___yes ___no
What if any, custody/access arrangements or orders do you have?

_____
_____

Can you provide copies of any court orders or written agreements regarding custody and access? ___yes ___no

Medical Alert (Transition Houses)

Medical or special needs:
___ access issues
___ allergies
___ dietary concerns
___ medications
___ other
Dr.'s Name:_____ Tel._____

Emergency contact:
Name_____ Relationship_____
Tel._____ Address_____

Special Needs

Do you have any special needs that you feel it would be helpful for us to know about so that we can be of most support to you?

_____
_____

Adapted from Sample Drugs Policy For Use By Domestic Violence Services.

SAMPLE LETTER TO ADVISE ON SUBSTANCE USE POLICY

DATE:

Dear _____,

When you moved into the Transition Housing program you would have been advised that we have a substance policy. We have this policy because we believe all people have the right to live free from violence, including women who use substances.

It is our legal obligation to reminder you of the content of this policy from time to time.

Therefore we would like to remind you of a few key points from the policy:

- We cannot hold onto your prescribed medication.
- It is illegal for you to give, share or supply any illegal drugs or prescribed medication. Doing so could mean you are issued with a warning or eventually re-housed.
- Do not use any prescribed or illegal drugs in communal areas.
- Please store any prescribed or illegal drugs in the locked cupboard in your room.
- It is unacceptable to discriminate against other people who may use substances e.g. name calling or exclusion.

Please follow these simply guidelines, as our goal is to run a safe, legal and secure Transition Housing program.

If you have any questions or would like a copy of the drugs policy, please feel free to ask a member of staff.

Yours sincerely,

The Friendly Management

From Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services (2000). Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse. Available at http://new.vawnet.org/Assoc_Files_VAWnet/IllinoisManual.pdf

SAMPLE MUTUAL SERVICES (LINKAGE) AGREEMENT
XYZ ADDICTIONS TREATMENT CENTER

The purpose of this document is to formalize the relationship between XYZ Addictions Treatment Center and the ABC Shelter. This cooperative and reciprocal arrangement will expedite referral, admission, and discharge of clients, allowing both agencies to serve clients better.

XZY Center will provide the following:

- Referrals of clients in need of safety planning, shelter and support
- Assessment services for substance abuse and chemical dependence
- Level I services for women Conventional outpatient services
- Level II services for women Intensive outpatient or partial hospitalization services
- Level III services for women Residential Treatment services
- Non-medical detoxification for women
- Case management services related to substance abuse treatment

ABC Center will provide the following:

- Referrals of clients in need of substance abuse treatment
- Assistance with safety planning for XYZ Center clients
- Shelter on a space-available basis for clients leaving substance abuse treatment who have been identified as victims of domestic violence
- Weekly support group for XYZ clients who have been identified as victims

Both parties to this agreement consent to abide by federal and Illinois standards regarding the confidentiality of client information, and to defend against efforts to obtain that information without the client's consent. Services will be provided under each party's usual arrangements for payment and/or funding and this agreement is not a guarantee that treatment slots or shelter beds will be available.

From Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services (2000). Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse. Available at http://new.vawnet.org/Assoc_Files_VAWnet/IllinoisManual.pdf

Qualified Service Organization Agreement (Sample)

XYZ Services Center ("the Center")
And the (Name of the Program)
("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide

_____
_____
_____
_____
_____
_____
_____
_____
(nature of services to be provided)

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and
2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

Executed this _____ day of _____.

_____ _____
President Program Director
XYZ Service Center (Name of Program)
(Address) (Address)

From Parkes, T. (2006). The Importance of Safe Conversations: Identifying Risk and Resources. In Armstrong, S. (Ed.). Freedom From Violence: Tools for Working with Trauma, Mental Health and Substance Use. Vancouver, BC: Ending Violence Association of BC's

Strategies to Cut Back on Substance Use and Dealing with Cravings

Encourage your client to try some of the following strategies to cut down her substance use:

- Plan the substance use.
- Set limits on the day, time and amount of use (e.g. only after 8:00 PM, only on weekends, etc.).
- Try to have at least two substance-free days per week.
- Delay the first use and each use after that.
- Find something else to do as a distraction from wanting to use more.
- Arrive at the dealer later than usual.
- Leave the dealer earlier than usual.
- Spend time with someone who will support your efforts to cut down.
- Avoid situations where you are likely to use or where you use a lot.
- Plan what days will be normal use and what days will be heavier use.
- Prepare only a little of the substance at a time, even if you intend to use more.
- Place the substance in a place that is hard to get to, or give it to someone who is supportive of your efforts to cut down.
- Reduce your tolerance so you need less.
- Keep a record of how much you are using and check whether you are meeting your goals.
- Do not try to keep up to other people; go at your own pace.
- Take only as much cash as you need when you go out, ensuring you have enough to get home.
- Ask a support person to accompany you when you cash your social assistance cheques.
- Leave your ATM card at home.

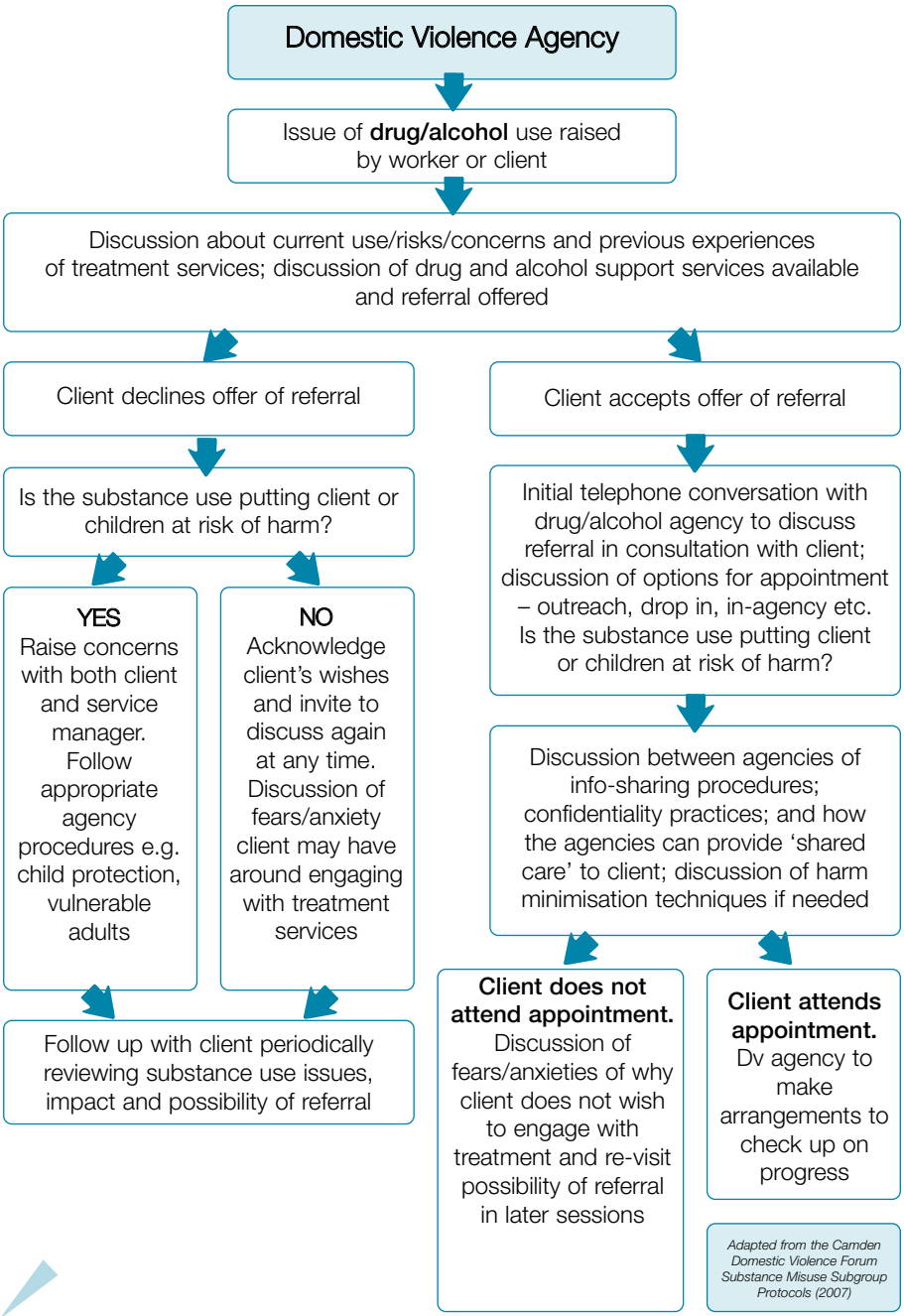
Suggest the following strategies for dealing with cravings:

- Identify when the craving starts; knowing what is going on is the first step in doing something about it.
- Remind yourself that cravings are a normal part of cutting down and that they will pass with time; the more you give into cravings, the stronger they become.
- Remember that cravings are like a hungry cat: the more you feed it the more it comes back.
- If you don't feed it, the cat eventually stops coming back.
- Try to find something to distract you, even if this only delays you from using the substance.
- Try to learn when you are most likely to crave the substance—for example, in certain situations, with particular people, when you feel a certain way—and plan how you will deal with each situation when it comes up.
- Delay using for an hour or even five minutes. When the time is up, delay for another hour, then another hour and so on. It is easier to resist cravings for a manageable period of time than to try to stop forever.
- Talk to someone supportive when you start to get cravings.
- Do something relaxing and enjoyable instead, like having a bath or a shower, having a massage or using aromatherapy products to induce relaxation.
- If you are able, go for a walk or a run or do some other physical exercise.
- Visit friends who don't use the substance or won't while you are there.
- Watch a video or go to a movie.
- Listen to relaxation tapes.

Against Violence & Abuse. (2007). Stella Project Toolkit.

13. Sample referral pathway:

Domestic Violence Agency to a Substance Misuse Agency



Reducing Barriers Appendix

Reducing Barriers
to Support for Women Fleeing Violence

A Toolkit for Supporting Women with
Varying Levels of Mental Wellness and Substance Use

Appendix Table of Contents

GLOSSARY OF TERMS

Abstinence

An approach to supporting women that focuses on women discontinuing their use of substances while in a program. Requiring women who are experiencing violence to abstain from substance use can put them at further risk of violence and without withdraw support can be dangerous. Stopping substance use altogether should be done with support and care. Abstinence and harm reduction are often framed as in opposition to one another, but many activists seem them as different approaches that may be offered along a continuum of service to better meet the varied needs of women.

Harm Reduction

An approach to supporting women that focuses on reducing the harms associated with a particular behaviour. For example, providing women with safe shelter and support whether she leaves her abuser or not is a form of harm reduction. Harm reduction and abstinence are often framed as in opposition to one another, but many activists seem them as different approaches that may be offered along a continuum of service to better meet the varied needs of women.

Intersectional Feminist Framework

Feminism means different things to different people. We use the term Intersectional Feminist Framework to include a gender based analysis, but also to take into consideration other social structures and power relations that impact women's lives (ex. racism, ableism, heterosexism etc). From this framework, it is important that we reflect on our own social positions in our daily interactions – what are our interested, perspectives and in what ways do we hold and exert power? This enables us to strategize around how to make our services more inclusive by asking questions about who is included and who is missing – who is heard and who is silenced?

Low Barrier

Term used to refer to programs that typically accept women or people accessing services that are often denied service at other organizations based on their levels of mental wellness or substance use. Often low barrier programs attempt to meet people where they are at rather than requiring the service recipient to abstain from substance use, for example, or to be stable on medications as long as they are respectful of others in the program. The goal is to have as few barriers to services as possible.

Mental Wellness

While we may not all have a clinical diagnosis, we all have varying levels of mental wellness. We use the term 'mental wellness' to draw attention to the fact that our mental wellness exists on a continuum and is fluid and changing. We emphasize that mental wellness itself cannot be considered a problem, but we must consider what problems are created by our levels of mental wellness. This term has less stigma and judgment associated with them than other terms commonly used.

Policies

Policies, as used in this toolkit, are written statements which describe positions on/decisions about which describe an overall position or plan specific to) a certain area of operation within Transition Housing programs.

Procedures

Procedures as used in this toolkit, are part of a written policy and provide direction for how policies are to be put into practice.

Practices

Practice is the way we put policies and procedures into action in our day-to-day work in Transition House programs.

Safe Home

Short term [generally, not to exceed 5 days] emergency housing in private home [or in rental units].[i]

Second Stage House

Long term (generally 3-12 months) secure housing

with support designed to assist women while they search for permanent housing.[ii]

Substance Use

We use the term 'substance use' to draw attention to the fact that our substance use exists on a continuum and is fluid and changing. Like mental wellness, we emphasize that substance use itself cannot be considered a problem, but we must consider what problems are created by our levels of substance use. This term has less stigma and judgment associated with them than other terms commonly used.

Sexual Orientation

Used to refer to romantic or sexual attraction. Like gender, sexual orientation is often seen as fixed and dichotomous (straight or gay), but can be much more complex.

Third Stage House

Supportive housing for women who have left violent relationships and who no longer need crisis service supports.

Trans

An umbrella term often used in transgender communities to demedicalize the words used to describe people whose assigned biological sex does not align with the gender they identify with or who see their gender as more fluid than the traditional masculine/feminine binary.[iii]

Transition House

Short to moderate term [in BC a short to moderate term is 30 days] first stage emergency housing.[iv]

Transition Housing Program

This term is used throughout the Reducing Barriers toolkit to refer to Transition House, Second Stage and Safe Home programs.

Trauma

The Women Abuse Response Program (WARP) at BC Women's Hospital and Health Centre notes that the term 'trauma' has historically been used in the mental wellness and substance use fields and, in those contexts, has been "devoid of a gender-based analysis". With its adoption into the Violence Against Women's movement to describe women's experiences with violence, some worry that the importance of gender will be lost. Framing violence as 'a traumatic experience' may individualize violence against women. WARP recommends that, "trauma, particularly complex post-traumatic stress… be recognized as one of many impacts of violence against women", rather than a description of violence against women in and of itself.[v]

Trigger

Trigger' is used to refer to an event that encourages or prompts thoughts about using substances or, in the context of mental wellness, brings about symptoms related to mental wellness.

Violence Against Women

BCSTH uses the term 'violence against women' (VAW) as it captures violence a woman experiences from her partner but is also applicable for other people she may be oppressed by (for example, family, landlord, co-worker and broader social systems). The term can be applied to many types of harmful behaviour directed at women and girls because of their sex.[vi] Depending on the resources available to the agency, the needs of women in the community and the political stance, Transition Housing programs fin BC may focus solely on violence against women in relationships while others support women who experience violence from a wide-range of individuals and systems.

Violence against women hinges on control and domination. Each woman's experiences of violence are unique and are shaped by her social context.

i Statistics Canada. (2001/02), Juristat, 23(4).

ii Ibid.

iii Qwo-Li Driskill. (2008). Gender Glossary. Retrieved November 3, 2009, from www.dragonflyrisng.com/organizers.php

iv Statistics Canada, 2001/02.

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IMPORTANT CONTACTS

EMERGENCY NUMBERS

General
911 or local police department

Children/Youth
Kid's Help Phone
1-800-668-6868

Poison Control Centre
1-800-567-8911/ 604-682-5050
www.dpic.org

Suicide/Distress
Crisis Centre
1-800-SUICIDE (784-2433)

Local Crisis Line
310-6789 (do not add area code)

Violence
911
or local police department
or VictimLink
1-800-563-0808
604-875-0885 (TTY – dial 711 for collect call)
604-836-6381 (text)

MENTAL WELLNESS & SUBSTANCE USE RESOURCES AND REFERRAL AGENCIES

Alcohol & Drug Information & Referral Service
1-800-663-1441/ 604-660-9382

BC Mental Health & Addictions Services
www.bcmhas.ca

BC Partners Mental Health Information Line
1-800-661-2121/ 604-669-7600

Eating Disorders Resource Centre
1-800-665-1822/ 604-806-9000

HealthLinkBC
811/ 711 (TTY)
www.healthlinkbc.ca

HeretoHelp
(Mental Health & Substance Use Information)
310-6780
(no area code – crisis calls, support & referrals)
www.heretohelp.bc.ca

Problem Gambling Help Line
1-888-795-6111
604-875-0885 (Deaf or hearing-impaired)
www.bcresponsiblegambling.ca

RESOURCES BY HEALTH AUTHORITY

Fraser Health Authority
www.fraserhealth.ca

Mental Wellness
www.fraserhealth.ca/your_care/mental_health_and_substance_use/mental_health_services/

Substance Use
www.fraserhealth.ca/your_care/mental_health_and_substance_use/substance_use_services/

Interior Health Authority
www.interiorhealth.ca

Mental Wellness & Substance Use
www.interiorhealth.ca/health-services.aspx?id=5556

Northern Health Authority
www.northernhealth.ca

Mental Wellness & Substance Use
www.northernhealth.ca/YourHealth/MentalHealthAddictions.aspx

Vancouver Coastal Health Authority
www.vch.ca

Mental Wellness & Substance Use
www.vch.ca/our_services/find_health_services/find_services

A searchable database of services – search using drop down menu 'By Health Topic' for either 'Addictions' or 'Mental Health'

Vancouver Island Health Authority
www.viha.ca

Mental Wellness & Substance Use
www.viha.ca/mhas/

OTHER RESOURCES

ABILITIES

BC Coalition of People with Disabilities
1-800-663-1278/ 604-872-0188
www.bccpd.bc.ca

ABORIGINAL

Ministry of Aboriginal Relations and Reconciliation's Guide to Aboriginal Organizations and Services
www.gov.bc.ca/arr/services/guide.html

Aboriginal Health Program,
BC Women's Hospital & Health Centre
604-875-2348
www.bcwomens.ca/Services/AboriginalHealth

Association of BC First Nations Treatment Programs
250-503-1135
www.firstnationstreatment.org

BC Aboriginal Child Care Society
604-913-9128
www.acc-society.bc.ca

BC Assembly of First Nations
604-922-7733
www.bcafn.ca

British Columbia Aboriginal Network on Disability Society
1-888-815-5511 (TTY accessible)
250-381-7303
www.bcands.bc.ca

British Columbia Association of Aboriginal Friendship Centres
1-800-990-2432/ 250-388-5522
www.bcaafc.com

Caring for First Nations Children Society
1-800-342-4155/ 250-391-0007
www.cfncs.com

Indian Residential School Survivor's Society
1-800-721-0066/ 604-925-4464
www.irss.ca

Métis Nation of British Columbia
1-800-940-1150/ 604-557-5851
www.mnbc.ca

Native Courtworker and Counselling Association of British Columbia
1-877-811-1190/ 604-985-5355
www.nccabc.ca

Office of the Provincial Advisor for Aboriginal Infant Development Programs
250-388-5522
www.aidp.bc.ca

BEREAVEMENT

BC Bereavement Helpline
1-877-779-2223/ 604-738-9950
www.bcbereavementhelpline.com

CAREGIVERS

Family Caregiver Network Society
1-877-520-3267
250-384-0408
www.fcns-caregiving.org

CHILDREN AND YOUTH

BC Children's Hospital Specialized Eating Disorders Program
604-875-2010
www.bcchildrens.ca/ServicesChildYouthMentalHlth/ProgramsAndServices/ProvincialSpecializedEatingDisordersProgram/default.htm

BC Helpline for Children
310-1234 (no area code required)
www.safekidsbc.ca

Children Who Witness Abuse – Counselling Information Contact List
www.pssg.gov.bc.ca/victimservices/directory/docs/children-who-witness-abuse-counselling.pdf

The F.O.R.C.E. Society for Kids' Mental Health
604-878-3400
www.bckidsmentalhealth.org

Kelty Resource Centre
1-800-665-1822/ 604-875-2084
www.keltymentalhealth.ca

McCreary Centre Society (research and resources)
604-291-1996
www.mcs.bc.ca

Ministry of Children and Family Development
General
1-877-387-7027
250-387-7027 (Victoria)

After hours Emergency
1-800-663-9122
604-660-4927 (Vancouver, North Shore, Richmond)
604-660-8180 (Lower Mainland from Burnaby & Delta in West to Maple Ridge and Langley in East)

Representative for Children and Youth
1-800-476-3933
www.rcybc.ca

Youth Against Violence Line
1-800-680-4264
604-875-0885 (TTY)
604-836-6381 (text)
www.youthagainstviolenceline.com

COGNITIVE IMPAIRMENTS

Autism Society of BC
1-888-437-0880/ 604-434-0880
www.autismbc.ca

Community Living British Columbia
1-877-660-2522/ 604-664-0101
www.communitylivingbc.ca

FRANCOPHONE WOMEN

Societé Inform'Elles
604-736-6976
www.informelles.org

GOVERNMENT – GENERAL

General enquiries/Redirect to appropriate place
1-800-663-7867
604-660-2421 (Vancouver)
250-387-6121
1-800-661-8773
604-775-0303 (TTY)
www.extranet.gov.bc.ca/forms/gov/contact/index.html

ServiceBC
www.servicebc.gov.bc.ca

HEALTH - GENERAL

BC NurseLine/HealthLink
811/ 711 (TTY)
www.healthlinkbc.ca

BC Women's Hospital & Health Centre
1-888-300-3088/ 604-875-2424
www.bcwomens.ca

British Columbia Centre of Excellence for Women's Health (research and resources)
1-888-300-3088 x. 2633/ 604-875-2633
www.bccewh.bc.ca

HIV/AIDS

Healing Our Spirit BC Aboriginal HIV/AIDS Society
1-266-745-8884/ 604-879-8884
www.healingourspirit.org

Positive Living BC
1-800-994-2437/ 604-893-2200
www.positivelivingbc.org

Positive Women's Network
1-866-692-3001/ 604-684-3126
www.pwn.bc.ca

HOUSING

BC Housing
www.bchousing.org

BC Non-Profit Housing Association
1-800-494-8859/ 604-291-2636
www.bcnpha.ca

Tenant Resource & Advisory Centre (TRAC)
1-800-665-1185/ 604-255-0546
www.tenants.bc.ca

Co-operative Housing Federation of BC
1-866-879-5111/ 604-879-5111
www.chf.bc.ca

Co-op Directory
www.chf.bc.ca/pages/directory.asp

Residential Tenancy Branch,
Office of Housing and Construction Standards
1-800-665-8779
604-660-1020
250-387-1602
www.rto.gov.bc.ca

LEGAL SUPPORT & INFORMATION

Access Probono
1-877-762-6664/ 604-878-7400
www.accessprobono.ca

BC Human Rights Coalition
1-877-689-8474/ 604-689-8474
www.bchrcoalition.org

BC Human Rights Tribunal
1-888-440-8844
604-775-2000
604-775-2021 (TTY)
www.bchrt.bc.ca

BC Laws
1-866-236-5544/ 604-927-2914
www.bclaws.ca

British Columbia Public Interest Advocacy Centre
604-682-7896
www.bcpiac.com

Canadian Human Rights Commission
1-888-214-1090
613-995-1151
1-888-643-3304 (TTY)
www.chrc-ccdp.ca

Clicklaw
www.clicklaw.bc.ca

Community Legal Assistance Society
1-888-685-6222/ 604-685-3425
www.clasbc.net

Dial-A-Law
1-800-565-5297
604-687-4680 (Lower Mainland)
www.dialalaw.org

JusticeBC
www.justicebc.ca

Justice Education Society
604-660-9870
www.justiceeducation.ca

The Law Society of BC
1-800-903-5300/ 604-669-2533
604-443-5700(TTY)
www.lawsociety.bc.ca

Lawyer Referral Service
1-800-663-1919/ 604-687-3221
www.cba.org/bc/Public_Media/main/lawyer_referral.aspx

Legal Services Society
1-866-577-2525/ 604-408-2172 (Greater Vancouver)
www.lss.bc.ca

Ministry of Attorney General
1-888-663-7867
604-660-2421 (Vancouver)/ 250-387-6121 (Victoria)
1-800-661-8773
604-775-0306 (Vancouver) (TTY)
www.gov.bc.ca/ag

Court Services
1-800-663-6102/ 250-953-8200 (Victoria)
https://eservice.ag.gov.bc.ca/cso/index.do

Dispute Resolution Office, Justice Services
250-387-1480

Family Justice Programs, Justice Services
250-356-6582
www.ag.gov.bc.ca/family-justice/index.htm

Family Maintenance Enforcement Program
1-800-663-7616/ 250-220-4040
www.fmep.gov.bc.ca

Office of the Police Complaint Commissioner
1-877-999-8707/ 250-356-7458
www.opcc.bc.ca

Ombudsperson
1-800-567-3247/ 250-387-5855 (Victoria)
www.ombudsman.bc.ca

Office of the Information & Privacy Commissioner for British Columbia
1-800-663-7867 (request transfer to 250-387-5629)
250-387-5629
www.oipc.bc.ca

Probono Map of BC
www.probonomap.bc.ca

Protection Order Information
www.pssg.gov.bc.ca/protection-order-registry

Provincial Court of British Columbia
www.provincialcourt.bc.ca

Public Guardian and Trustee
1-800-663-7867
604-660-2421 (Vancouver)
250-387-6121 (Victoria)
www.trustee.bc.ca

Westcoast LEAF
1-866-737-7716/ 604-684-8772
www.westcoastleaf.org

LESBIAN, BISEXUAL, QUEER & TRANS

Prism Alcohol and Drug Services (Vancouver)
604-685-1214
www.vch.ca/prism

QMUNITY
1-800-566-1170 (Prideline BC)/ 604-684-6869

MENTAL WELLNESS

Alzheimer Society of BC
1-800-936-6033
604-681-8651 (Dementia Helpline)
www.alzheimerbc.org

Anxiety BC
604-525-7566
www.anxietybc.com

BC Reproductive Mental Health Program
www.bcwomens.ca/Services/HealthServices/ReproductiveMentalHealth/default.htm

BC Schizophrenia Society
1-888-888-0029/ 604-270-7841
www.bcss.org

Canadian Mental Health Association of BC
1-800-555-8222/ 604-688-3234
www.cmha.bc.ca

Jessie's Legacy Program
(Eating Disorder Resources)
1-888-988-5281
www.familyservices.bc.ca/professionals-a-educators/jessies-legacy

Ministry of Health
1-800-663-7867
604-660-2421 (Vancouver)
250-387-6121 (Victoria)
1-800-661-8773
604-775-0303 (TTY)
www.health.gov.bc.ca/mhd/index.html

Mood Disorders Association of British Columbia
604-873-0103
www.mdabc.net

Open Door Group
604-734-0777
www.opendoorgroup.org

PeerNetBC
604-733-6186
www.peernetbc.com

Peggy's Place, The Kettle Friendship Society
(Lower Mainland)
604-430-6644
www.thekettle.ca/programs.aspx

OLDER WOMEN

The BC Centre for Elder Advocacy and Support
1-866-437-1940/ 604-437-1940
www.bcceas.ca

POVERTY

Ministry of Social Development and Responsible for Multiculturalism
1-800-663-7867
604-660-2421 (Vancouver)
250-387-6121 (Victoria)
1-800-661-8773
604-775-0303 (Vancouver) (TTY)
www.gov.bc.ca/hsd

SETTLEMENT/MULTICULTURAL

Affiliation of Multicultural Societies and Services Agencies of BC (AMSSA)
1-888-355-55560/ 604-718-2780
www.amssa.org

S.U.C.C.E.S.S.
(Lower Mainland & Fort St John)
604-684-1628
www.successbc.ca

Immigrant Services Society of British Columbia
(Lower Mainland)
604-684-2561
www.issbc.org

MOSAIC (Lower Mainland)
604-254-3932
www.mosaicbc.com

SUBSTANCE USE

Aurora Centre,
BC Women's Hospital & Health Centre
www.bcwomens.ca/Services/HealthServices/AuroraCentre

Centre for Addictions Research of BC (research and resources)
250-472-5321/ 604-408-7753
www.carbc.ca

Fir Square (pregnant women and new mothers)
604-875-2229
www.bcwomens.ca/Services/PregnancyBirthNewborns/HospitalCare/SubstanceUsePregnancy.htm

Ministry of Health
1-800-663-7867
604-660-2421 (Vancouver)
250-387-6121 (Victoria)
1-800-661-8773
604-775-0303 (TTY)
www.health.gov.bc.ca/mhd/index.html

VIOLENCE AGAINST WOMEN

Battered Women's Support Services
1-855-687-1868/ 604-687-1868
www.bwss.org

BC Society of Transition Houses
1-800-661-1040/ 604-669-6943
www.bcsth.ca

Counselling and Outreach Programs
www.pssg.gov.bc.ca/victimservices/directory/index.htm

Crime Stoppers
1-800-222-TIPS (8477)
www.bccrimestoppers.com

Ending Violence Association of BC
604-633-2506
www.endingviolence.org

Ministry of Public Safety and Solicitor General
Victim Services and Crime Prevention
604-660-5199
Crime Victim Assistance Program
1-866-660-3888/ 604-660-3888
Victim Safety Unit (Victim Notification)
1-877-315-8822/ 604-660-0316
www.gov.bc.ca/pssg/

Police Victim Services Association of BC
1-877-869-0720/ 604-501-2502
www.policevictimservices.bc.ca

Sexual Assault Services, BC Women's Hospital & Health Centre (offer training throughout BC)
604-875-2881
www.bcwomens.ca/Services/HealthServices/Sexual+Assault+Services/EducationTraining.htm

Transitional Housing Programs
www.bchousing.org/Options/Emergency_Housing/WTHSP/Access

Woman Abuse Response Program at BC Women's Hospital & Health Centre
604-875-3717
www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/default.htm

Adapted from Advancing Health Care Practices: Exploring the Links Between Woman Abuse, Substance Use, and Pregnancy/Early Parenting. Developed by and with permission from Atira Women's Resource Society and Woman Abuse Response Program.

Mental Wellness		
Program	Contact	Comments
Substance Use		
Program	Contact	Comments
Housing		
Program	Contact	Comments
Legal Issues		
Program	Contact	Comments
Culture/Language		
Program	Contact	Comments

Comments might include: hours, age limits, requirements (ex. abstinence, picture identification), cost, availability of childcare, geographical boundaries, drop-in or appointment, length of waiting list, etc.

SAMPLE POLICIES

SAMPLE ADMISSIONS POLICY

Rationale

XYZ Transition House program provides support and shelter to women who have experienced violence. Women who access our program are often in crisis and experiencing various effects of violence against women they have experienced. XYZ Transition House program's immediate goal is to ensure our services accommodate and provide safe refuge for women and support women through all of these effects.

Women's experiences of violence are not universal and XYZ Transition House program aims to provide a range of services and supports that are flexible to meet the needs of each unique woman who accesses our services.

Policy

XYZ Transition Housing program welcomes all women who have experienced violence whose needs can be met by the current resources of the XYZ program.

Procedures

Before Entry

Establish right away that a woman is currently safe. If she is not, inform her of how she may find a safe place to contact you.

At the beginning of any conversation with women, inform women of XYZ's confidentiality policy and the limits of confidentiality.

Women wanting to access XYZ Transition House Program are informed of our supports and services we offer as well as our limitations.

- During this initial conversation, staff will find out whether women feel their needs can be met by the program
- Based on the needs of the woman, program staff will assess whether XYZ program can meet the needs of and accommodate the woman

Before a woman enters the XYZ Transition House program staff will make the woman aware of/that:

- The various services and supports the program offers
- Programming is optional and her participation in any programming is not required
- That the program supports women who have varying levels of mental wellness and/or substance use
    - Staff may briefly explain how mental wellness and substance use are connected to experiences of violence for many women
    - Staff will ask whether this will pose any problems and determine how women may be supported through any challenges and if another service may be a better fit

When Unable to Provide Shelter/ Housing to a Woman

If XYZ program is unable to physically shelter a woman due to limited resources the first priority will be to find her another safe shelter. Arrangements will be made to provide support via phone, through XYZ's outreach services where applicable, or through other means.

If XYZ Transition House program is unable to accommodate a woman in our housing and support programs or if a woman decides our program is not a good fit staff will make an appropriate referral that is a good fit for the woman.

During Entry/Admission/Intake

Staff will assess on a case-by-case basis how much detail/how long the initial orientation should be based on a woman's current needs. Conversations will be on-going, but at the least, as a woman enters the program staff will:

- Assess whether a woman needs medical attention
- Outline any confidentiality policies/limitations
- Give women a copy of the intake form
    - To be filled out with the woman or collected from the woman within 24 hours of the woman entering the program
- Give women a copy of the program guidelines
    - Staff will go over these guideline with woman at time of entrance or within 24 hours
- Inform women of their rights and responsibilities
    - NOTE: Your program should have these in written form
- Inform women of an emergency/safety policies and procedures
- Provide details about the operation of the program, including a support person the woman may connect with
- Provide information about complaint procedures
- Provide a tour of the program space

Staff will ask women how best they can support them and ensure they are comfortable in the program.

Program staff will make appropriate arrangements to ensure that women who do not read or speak English are accommodated.

SAMPLE MENTAL WELLNESS POLICY

Rationale

XYZ Transition Housing program recognizes that violence has various effects on women and women's health, including levels of mental wellness. For many women, experiences of violence can affect a woman's level of physical and sense of mental well-being. Often, women are given mental wellness diagnoses with little or no consideration of the role that experiences of violence plays. In fact, changes in women's levels of mental wellness are a normal and adaptive response to experiences of violence and oppression.

Our first priority is always to find ways to ensure that women who have experienced violence can access and stay in XYZ's housing program or continue to access our supports.

Policy

XYZ Transition Housing program aims to support women through all the effects of violence. Our foremost goal is to find ways to ensure women can stay in XYZ program or continue to access our supports.

A woman's level of mental wellness alone is not a reason to deny her access to the program or to ask her to leave. Focus will be placed instead on whether or not a woman's behaviour can be accommodated with the current resources of the XYZ Transition Housing Program.

Procedures

<u>At Entrance/Admission/Intake</u>
The following procedures around mental wellness are to be followed when engaging with every woman who comes to the program:

- During entrance/intake tell women that the program accepts women regardless of where they may be in the continuum of mental wellness [see Sample Admission Policy]
- Open discussion about whether this will be a problem and how you can support her
- Staff will only ask women about their mental wellness as it relates to enhancing service provision, i.e. informing safety planning processes or meeting women's referral needs [See Reducing Barriers toolkit for more information]
- Provide information about safe storage of any mental wellness medications
- Begin conversations about how best to support women when they are distressed

<u>Ongoing Support</u>
The following approaches will be used when supporting women in the XYZ program:

- Provide opportunities for women to think and talk about their mental wellness and its connection to violence and other forms of oppression
- Have ongoing conversations about the effects of violence, including women's mental wellness, her feelings about her levels of mental wellness and any goals a woman may have
- Have ongoing conversations about how best to support individual women when they are distressed or experiencing mental wellness symptoms/responses
- Provide non-judgmental support when women are experiencing mental wellness symptoms/responses [See Reducing Barriers toolkit]
- Whenever possible, staff will have conversations with women about how best to support them before they are in crisis or experiencing symptoms/responses related to mental wellness
- Provide referrals when requested and support women to access referred agencies

<u>Medication Storage</u>

- Lockboxes will be provided for storage of any medications or any items that women need secured or that may be unsafe for others
- Staff will provide women with the option of having medications stored in staff possession but

women will not be required to turn medication over to staff

- Staff will support women who express their need for assistance/reminders to take medication
- Staff may ask women whose behaviour is disruptive to spend some time in a more private area. Whenever possible, staff will have conversations about why they may ask women to move to a private area before any need to do so might arise
- If a woman has medications stored unsafely on-site, staff will have a conversation with the woman to talk about why the guidelines are in place and ask how best to support her to adhere to them (for example, using provided lockboxes or having medications in a safe central location).
- Staff will not dispense medications to women.

SAMPLE SUBSTANCE USE POLICY

Rationale

XYZ Transition Housing program recognizes that violence has various effects on women and women's health, including levels of substance use. For many women who have experienced violence, substance use may be a way to cope.

Our first priority is always to find ways to ensure that women who have experienced violence can access and stay in XYZ's housing program or continue to access our supports.

Policy

XYZ Transition Housing program aims to support women through all the effects of violence. *Our foremost goal is to find ways to ensure women can stay in XYZ program or continue to access our supports.*

A woman's substance use alone is not a reason to deny a woman access to the program or to ask her to leave. Focus will be placed on behaviours and whether they can be accommodated with the current resources of the XYZ Transition Housing Program.

Procedures

<u>Substance Use and Substance Use Supplies On-Site</u>

- Women are encouraged not to use substances on-site
- Staff will work with women and other community service providers to find a safe place to use substances
- Staff will engage in ongoing conversations with women and community members about the workability of this policy/procedure
- Lockboxes will be provided for storage of any items that women need secured or that may be unsafe for others
- Staff will provide access to safe substance use supplies either within the program or through partnership with other community agencies
- Women are able to return to the program having used substances. Staff may ask women whose behaviour is disruptive to spend some time in a more private area. Whenever possible, staff will have conversations about why they may ask women to move to a private area before any need to do so might arise.

<u>At Entrance/Admission/Intake</u>

The following procedures around substance use are to be followed with every woman who comes to the program:

- During entrance/intake tell women that the program accepts women regardless of where they may be in the continuum of substance use [see Sample Admission Policy]
- Open discussion about whether this will be a problem and how you can support her
- Outline and provide rationale for any rules or guidelines around substance use or storage of substances on-site
  NOTE: *This will vary depending on your policies on substance use on site and substance use supplies on site*
- Staff will only ask women about their substance use as it relates to enhancing service provision, i.e. informing safety planning processes or meeting women's referrals needs [See Reducing Barriers toolkit for more information]

<u>Ongoing Support</u>

The following harm reduction approaches will be used when supporting women in the XYZ program:

- Provide opportunities for women to think and talk about their substance use and its connection to violence and other forms of oppression
- Have ongoing conversations about women's substance use including feelings about substance use and any goals a woman may have
- Support women in any changes they identify and wish to make (focusing on the goals a

woman has for herself at this point in time)
- Make information available and provide information when needed on safe substance use practices
- Provide referrals when requested and support women to access referred agencies
- Support women who may feel 'triggered' by the substance use of other women in the program

If a woman has used substances or has substance use supplies stored unsafely on-site, staff will have a conversation with the woman to talk about why the guidelines are in place and ask how best to support her to adhere to them (for example, using provided lockboxes, suggesting alternate locations for substance use or safely disposing of substance use supplies).

Sample Harm Reduction Policy. Provided be South Okanagan Women in Need Society. With special thanks to Rhea Redivo who authored the policy.

HARM REDUCTION WITHIN THE TRANSITION HOUSE

Purpose

This harm reduction policy has been developed to ensure women who seek services at [Agency Name] and also have co-occurring substance use or mental health issues receive appropriate responses. Denying service on the basis of substance use or mental health issues is a form of institutional oppression that compromises women's health and safety, re-victimizes them, and validates their abusers, an outcome that is decidedly counterproductive and antithetical to [Agency Name]'s mission, philosophy, service mandate and goals. A harm reduction approach enhances both women's safety and service delivery.

Responsibility

[Agency Name] is mandated to provide services that help women stay safe. Denying service based on substance use or mental health issues or failing to take their role and impact into account in service and safety planning compromises women's health and safety. A harm reduction approach ensures women receive the services they need to improve their own safety, health and well-being.

[Agency Name] executive director and transition house program coordinator are responsible for providing the relevant procedures, tools and training necessary for staff to implement harm reduction strategies in every day practice. They are also responsible for ensuring cross-training and collaboration with, and education of, community agencies that serve women.

[Agency Name] staff is responsible for participating in the training provided and for implementing harm reduction strategies in a manner that reflects its underlying philosophy and values.

Definition of Harm Reduction

Traditionally, addictions services have focused on abstinence as the primary treatment goal. Harm reduction, however, acknowledges that abstinence, like substance use itself, exists on a continuum. Instead of being a discrete event, it is seen as a progressive, non-linear journey that is unique to each individual and entails both success and failure. For many, immediate and complete abstinence is not only unlikely, but an unrealistic expectation. Relapse and/or some degree of continued use is an inherent part of the recovery journey and therefore expected. The purpose of harm reduction strategies is to reduce the medical, personal and social risks and harms associated with substance use, particularly for the individual, but also for society. Not unlike the purpose of safety planning for women remaining in abusive situations, harm reduction strives to enhance clients' safety while still using and to reduce negative repercussions. In essence, harm reduction strategies ensure clients survive the various stages of their journey with minimal negative effects until such time as they achieve their ultimate goal: abstinence.

As with anti-violence services, the primary focus is safety. Other aspects are raising awareness, respecting choice, and empowering in order to enhance motivation to change. Change is a choice that requires time and commitment to one's best interests. It must be therefore be internally motivated, not externally imposed (Bland & Edmund, 2008). To that end, service is guided by individual need, readiness and choice. Emotional safety is essential. It entails acceptance, respect and gentle honesty while providing information and education that promote women's understanding of the impact of use on them and their lives, especially health and safety. Recognizing individual strengths and small successes provide encouragement, while acknowledging

underlying positive intentions and normalizing substance use as a response to abuse reduces guilt and shame. Empowerment and respecting choice help promote hope and self-confidence; giving information and raising awareness help increase desire to change. Together, they enhance internal motivation and the likelihood of change.

Fit with Transition House Services

The basic tenets of 'harm reduction' have long formed the basis for anti-violence practice, where the primary goal is to help women reduce, avoid or escape violence and to minimize its effects. Like abstinence, freedom from domestic violence may be the ultimate goal. However, rather than being a discrete event, it is a progressive, non-linear, process that is unique to the individual and occurs over time. Setbacks are also considered an inherent part of the journey and safety planning is standard practice.

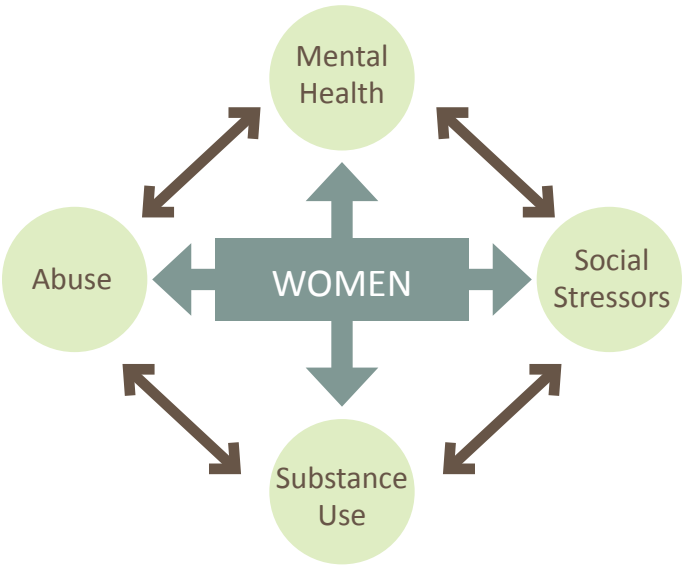
Individual choice, education, and empowerment are likewise key practice values, as is the underlying service goal is to reduce potential harm pending more substantial change. Women's needs, readiness and choices guide service provision. Women are not told what to do; they are given information, education and resources so they can decide for themselves what to do. Applying harm reduction requires these same practice values and principles be extended to women who have substance use or mental health issues. Imposing expectations that women immediately leave their abuser or 'do what we think' only revictimizes and disempowers, which undermines, rather than promotes, internal motivation.

Degree of risk

Although domestic violence, substance use, and mental illness often appear together, causal relationships remain unclear. Individually, each can be chronic, progressive, and potentially lethal. When combined, their severity and lethality increase.

Since substance use and mental health issues may increase women's risk for violence as well as the severity of violence, women accessing anti-violence shelters who also have co-occurring substance use or mental health issues are therefore at greater risk than those who do not. Mental health issues pose the additional risk of self-harm (Parkes, 2007d). Yet, service is often denied these women due to the very issues that place them at greater risk, which further compromises their safety.

The immediate danger posed by domestic violence is generally greater than that posed by substance use or mental health issues, yet either can be equally as lethal as any abuser (Bland, 2008). Policies must therefore strive to balance supporting abstinence with creating safety so that women unable to remain abstinent can ask for help.



Risk reduction involves providing appropriate, effective services for women experiencing both domestic violence and substance use or mental health issues so they can increase their own and their children's safety and well-being. A harm reduction approach ensures they receive the service they need regardless of these issues or their choices regarding treatment. Inviting women to examine their situations honestly through open, non-critical discussions that

also offer information and choices is a key strategy. In addition, substance use and mental health issues must be considered in women's overall safety plan, which may include identifying triggers for substance use or mental health behaviours, alternate responses, or skill development.

Risk reduction also involves addressing potential risks to other residents. Any concerns must be based on actual behaviour and clearly described. When concerns arise, explain the behaviour in question and invite the woman involved to consider its potential impact on others as well as to participate in problem-solving to identify appropriate behaviour, support needed, or consequences. (see Procedures for more detailed information on safety planning, screening, assessment, or exclusion)

Potential Benefits

Temporary respite from violence provides a window of opportunity for women to reflect not only on violence, but also on substance use or mental health issues and their impact on health, well-being and safety. Within the safe context of the transition house, women receive safety, support and information that allow them to consider their options. In addition to learning about resources and treatment options available to them, they may also learn alternative coping strategies. These tools allow women to make decisions about what will help them on their recovery journey (Bland & Edmund, 2008).

In this way, transition houses serve not only as a form of harm reduction, but also as a catalyst for change, and for women with co-occurring substance use, their stay in a transition house appears to be a first step to recovery. Whether brief or more substantive, substance use interventions within transition houses appear to help women alter their substance use (Bland & Edmund, 2008). Indeed, after their stay, motivation to use and levels of stress likewise decreased, while perceived ability to face challenges increased. While decline in use is greatest among those with the highest initial level of use and the most significant interventions in the transition house, reductions occurred regardless of the degree of intervention provided (Jategaonkar & Poole, 2004).

More substantive interventions result in more substantive personal change. Incorporating harm reduction and increasing levels of intervention would reduce clients' risks and provide the necessary support for them to achieve their goals of health and safety for themselves and their children.

Harm Reduction In The Transition House Context

Research has shown that the most effective intervention offers integrated support and treatment grounded in policies that recognize the overlap of violence, substance use and mental health issues as well as the context of social and structural determinants (SAMHSA as cited in Poole & the Coalescing on Women and Substance Use Virtual Community, 2007). To be effective, service must be grounded in an understanding of how these various issues interact to affect women's lives and safety.

Harm reduction values and principles must inform all aspects of policy, procedure and service provision. Approach to, and expectations of, clients must likewise reflect these values. Temporary abstinence or other limitations on behavior may be reasonable for some clients; however, for others they are unrealistic and pose a significant barrier, especially for those who still live with violence and have substance use or mental health issues. Imposing such expectations in these cases is contrary to the goals and values of anti-violence services. Encouraging reduction or safer choices may be both more reasonable and more successful.

Service provision must also recognize the potentially differing needs of women with co-occurring substance use or mental health issues. Accompanying memory distortions or cognitive deficits can affect

their ability to judge safety, recall incidents, report violence, and enact safety plans. They can also affect their ability to advocate for themselves (Bland & Edmund, 2008), which in turn compromises their capacity to get the help they need or interact effectively with service providers. To accommodate their needs, it may be necessary to repeat information, provide structure, simplify goals, or advocate on their behalf with other service providers so they can access necessary resources. Reducing social stressors like housing, relationships or finances, which likewise interact reciprocally with both substance use and mental health issues, continues to be a key service goal.

Employee expectations

Harm reduction requires that the issue be addressed. As Bland (2008) states, the "intervention is in the asking" (p. 6). While employees are not expected to become addictions or mental health counselors, they are expected to be aware of how substance use and mental health issues affect women's lives and interact with violence. They must be willing and able to create emotional safety for women, to discuss substance use or mental health issues non-critically and without labeling women or judging their treatment choices, and to make links between these issues and the violence they experience or other aspects of their lives. This requires a context of emotional safety. Equally necessary is a thorough knowledge of relevant services and resources, including the degree to which they provide gender-specific services and physical or psychological safety, as well as the potential risks and benefits they present. Providing women with information and choices allows them to decide what they need and how to get it (Poole & the Coalescing on women & substance use virtual community, 2007).

In order to admit a problem and ask for help, women need to feel emotionally safe. Emotional safety entails acceptance, sensitivity, gentle honesty and respect. Given the stigma and institutional oppression often associated with substance use or mental health issues, women may initially deny problems. Honesty requires trust, and for women whose trust in others and themselves has been repeatedly violated, emotional safety may take time. Blame and moral retribution not only compromise safety, but confirm the stigma they have experienced, aggravate the shame and guilt they already feel, and further alienate and disempower them while empowering their abusers.

Screening and Assessment

Given the high co-occurrence of domestic violence with substance use or mental health issues, routine screening and assessment for these issues must be universal. As with screening for violence, the primary purpose of screening for these issues is not to deny service, but to obtain information, in particular information that can help identify those women in need of specific types of support and are then given appropriate given appropriate choices that help ensure their survival (Bland & Edmund, 2008). In essence, the purpose of screening and assessment to improve the service women receive and thereby enhance their chances of survival despite the challenges they face until they are ready to make larger changes. Their underlying intent is inclusion, not exclusion.

Women are unlikely to identify themselves as addicted (Bland & Edmund, 2008) or mentally ill (Parkes, 2007a) unless their safety is assured. In-depth exploration of these issues is unlikely to occur until trust and safety are established. Initial screening is therefore to be specific and brief and conducted within a context of openness and acceptance. Assessment, which is broader and more comprehensive, begins only after the immediate crisis is over and a trusting relationship has been initiated. In any case, in order to promote safety, and thus disclosure, women are to be offered choices and informed of the reasons behind any questions they are asked.

Screening is to follow established guidelines. These are not to be mistaken for 'rules.' Each client is to be assessed on an individual basis that takes into account the degree of potential harm from her abuser(s), from substance use or mental health issues, or from systems. Exclusion of any kind is to be based solely on actual behaviour, not on assumptions or 'labels.'
Assessment, on the other hand, is an ongoing process that seeks to determine each woman's changing needs for safety and support during her stay at the transition house.

Safety and Safety Planning

Safety is always paramount, not just for the individual, but also for the group. Effective safety planning must consider individual patterns and consequences of behaviour, both in terms of how they affect women personally and their potential effect on other residents. Safety planning is to follow established guidelines within a context of collaboration, sensitivity and respect for all individuals concerned.

Resident Expectations

Creating a safe environment requires consistency, yet flexibility. Rules should be unambiguous, straightforward and specific. Above all, they must be few in number with both expectations and consequences clear and consistently applied. In contrast, guidelines should be wide-ranging and flexible so that enforcement can be responsive to individual needs and circumstances. 'Fairness,' like equity, is governed by relativity, and the underlying principle when enforcing rules and guidelines is always a consideration of each woman's best interests in any given situation.

HARM REDUCTION PROCEDURES

Background

Although causal relationships remain unclear, research and field experience demonstrate that substance use, mental illness and violence frequently appear together and interact reciprocally. Research also shows (Substance Abuse and Mental Health Services Administration as cited in Poole & the Coalescing virtual community, 2007) that services are more effective in reducing women's experiences of abuse, substance use, and mental health issues when they:

1. Recognize the overlap of the three issues;
2. Situate these problems in the context of social and structural determinants of health;
3. Respond with gender-based, integrated support and treatment.

A holistic, pragmatic approach within a harm reduction framework that focuses on safety is most effective. Key service goals include helping "women address the risks in their lives and increase their safety, support and general health and well-being" and offering them "greater opportunities for more realistic and sensitive safety planning" (p. 123, Parkes, 2007d). Women who seek anti-violence services and also have substance use or mental health issues have different and increased safety and service needs compared to those who do not. They therefore require a somewhat different approach. Given their greater risk for harm, inclusion in terms of access to services is critical. In addition, given their greater risk for stigmatization and isolation, inclusion in terms of a 'supportive community of women' is also vital.

Substance use and mental health issues are common responses to violence and initially develop as strategies to meet specific needs. As such they have underlying positive intentions regardless how harmful or risky they may seem now. Just as women did not choose the violence in their lives, they did

not choose these additional challenges, nor do they choose the social stigma these issues result in. Internalized, this stigma leads to guilt, shame, and self-blame as well as negative self-perceptions that themselves present barriers. Yet, with appropriate support, women facing these challenges are equally able to create positive change in their own and their children's lives.

Transition houses provide a safe context for women to begin examining their issues, gain information about resources, and make decisions about next steps (Poole & Coalescing virtual community, 2007). In fact, research shows that staying in a transition house is often a starting point, even a catalyst, for change (Greaves Chabot, Jategaonkar, Poole, & McCullough, 2006), and intervention need not be lengthy or intensive, nor does it require that women 'hit bottom' to be effective. Even the brief support and intervention available within a transition house is effective in reducing women's substance use, and the greater the intervention provided, the greater the changes. While the most helpful interventions appear to be those that are pragmatic and strengths-focussed, the central element in any effective intervention is the client-worker relationship and individual strengths, which have been found to be key predictors of positive client outcomes (Poole & Coalescing virtual community, 2007). Building a positive, trusting relationship is therefore as critical as enhancing strengths, skills and positive beliefs about themselves.

Underlying Principles of Harm Reduction

The long term goal of harm reduction may be abstinence, but its immediate, short term goal is safety, with enhancing awareness and internal motivation as secondary goals. Safety also includes reducing any potential negative consequences. Key guiding principles and values underlying harm reduction are similar to those within the anti-violence sector:

Guiding Principles
Safety
Inclusion
Information; education
Self-determination
Pragmatism

Practice Values
Offering acceptance, trust & emotional safety
Challenging negative beliefs gently & sensitively
Expressing genuine care & concern
Appreciating individual worth & strengths
Affirming personal experiences & will to survive

IMPLICATIONS FOR POLICIES AND PROCEDURES

To be effective, procedures and processes in all areas of practice must by informed by and consistent with harm reduction principles and values and its key goals of enhancing safety, raising awareness, and empowering. The underlying intent of all procedures, practices and decisions is inclusion, as opposed to exclusion. Information and options are to be offered, and choices respected. All questions, decisions, and consequences are to be clearly explained.

Blanket policies and rules often result in women being denied service, evicted, or required to comply with specific criteria or expectations against their will. Therefore, they are to be kept to a minimum, and, if unavoidable, they must be unambiguous, straightforward, and specific, with both expectations and consequences clearly stated and consistently applied.

Instead of 'rules,' day-to-day practice is to be governed by broad 'guidelines.' Guidelines that offer a wide range of options allow flexibility to respond to each unique situation on a case by case basis (Bland, 2008). 'Rules' and 'guidelines' are to be clearly distinguished and consistently applied, with clients made aware of expectations and conse-

quences so they fully understand what to expect. This is critical for empowerment.
Rules, guidelines and consequences are to be based on women's actual behaviour, not on labels or assumptions associated with substance use or mental health diagnoses. The label itself is not the safety concern, but the behaviours associated with it. Further, the effects of each on women are subjective and individual, so not all 'labels' manifest the same way in all women. Decisions about eligibility, expectations, or consequences, must be based on actual behaviour, not assumptions associated with on labels.

During screening or assessment, ask women how their specific issue affects them and what they actually do when under the influence of their substance or mental illness. Invite them to consider the potential impact of their behaviour on others, service provision or the agency itself. Inform women in advance of potential consequences for behaviour such as substance use during their stay in the transition house and offer them support in meeting these expectations. For example,

> *"Choosing to use while staying in the transition house is a choice that impacts the safety of others and may result in _____; this consequence is a direct result of that choice; if you are not sure you can safely choose to refrain from using during your stay, we will help you explore your options, which may include _____."*

Specific consequences for behaviour such as substance use must be both fair and personalized, taking each woman's individual circumstances into account. Decisions must therefore be made on a case-by-case basis and be linked directly to specific behaviour. When advising women of consequences, both the behaviour and the reasons underlying the decision must be made very clear.

Within the transition house, substance use and mental health issues must be dealt with promptly, preferably within the same or the next shift. Concerns are to be noted in the log or verbally, not in the client file or other permanent records. In addition, all substances and/or paraphernalia are to be removed from the premises to reduce access and/or likelihood of triggering relapse.

Implications for Service Provision

All aspects of service must be informed by an understanding of substance use and mental health issues. Their wide-ranging effects on women necessarily play a role in service provision, both in the types of service needed and the manner in which it must be provided. Support and advocacy for women with substance use or mental health issues may therefore look slightly different than for those without. Their effects on women's functioning may require workers to simplify goals, repeat information consistently, provide more structure, and advocate for their inclusion in other services.
Women with substance use or mental health issues may present more complex service needs, like:

- extensive and potentially negative history with service providers due to childhood abuse;
- issues related to drugs or medication, such as withdrawal or side effects from either;;
- warrants, criminal charges, court appearances or other legal system involvement;
- difficulties related to parenting, including abilities, child custody and/or visitation issues;
- poor overall health; need for or greater involvement with medical services;
- past or ongoing experiences of public or professional stigma and/or discrimination;
- denial of service; unavailability or inaccessibility when needed;
- poor self-esteem or self-worth; low self-efficacy; external locus of control.

Regardless, service always begins 'where the client is at.' Find out what they think is the best place to start their healing work and what their healing goals and timelines are. Additional elements in helping them achieve safety or change are providing information, promoting awareness, and empowering.

Provide information that helps them understand and contextualize their substance use or mental health issues (eg what causes them, their various effects, how addiction develops), as well as information that demystifies treatment and support options so they can choose where and how to begin their healing journey. Linking substance use or mental health issues with abuse or other experiences of gender-based violence not only contextualizes them, but also helps to normalize women's experiences (Bland, 2008). In addition to addressing women's pragmatic needs, other key service goals are to:

1. Mitigate the direct effects of abuse, substance use and mental health issues as well as internalized stigma on women's identity, skills, and abilities; the resulting guilt, shame and self-blame not only impact self-esteem and self-confidence, but also contribute to negative self-perceptions that can become part of their identity; enhance self-esteem, self-worth and strengths, and gently confront unrealistic and/or negative perceptions or beliefs;
2. Help women learn how to be healthy and sober in all life domains: healthy independence, relationships, parenting, recreational activities, social interactions; early onset of abuse, substance use, or mental health issues can result in gaps in those skills and abilities usually associated with maturation (Inaba & Cohen, 2000), and address any developmental gaps and support clients in learning new coping and interpersonal skills;
3. Help women identify the underlying needs and positive intentions of their current coping strategies and explore alternate ways to cope, interact, or feel empowered; without effective skills or strategies to replace their current ones, women may be unwilling or unable to give up them up; show how new skills or strategies gained in one domain can be applied to another;
4. Enhance internal motivation and self-efficacy; women may have little faith in their worthiness for, or ability to create, change, and with neither hope nor confidence, the prospect of change may be far too daunting; substantive change is therefore unlikely; offer and respect choices, provide the support they need to succeed, highlight their successes, and foster belief in their ability to improve their own and their children's lives;
5. Connect women with other women; one-one counselling is most effective when balanced by connection with other women through groups where they can share life experiences and wisdom; whether formal or informal, such groups create safe spaces to explore connections between substance use, violence, poverty, stress, health problems or other issues they experience and the social, gender-biases that create the context for their lives (Poole & Coalescing virtual community, 2007); they also help normalize and reduce both isolation and stigma.

Substance use or mental health are sensitive, highly charged issues and require emotional safety. The most helpful approach is a non-threatening, conversation that raises questions and gives information with the underlying goal of determining what women want or need for their healing journey, including the kind of support they desire. It may be helpful to initiate such conversations by beginning with their abusers, and then introduce the women's issues in the context of it being a common response to abuse (Bland, 2008). For example,

> *Abuse often involves use of drugs/alcohol; was this the case in your situation? What was his drug of choice and how did it affect him? Sometimes abusers force women to use; other women use to cope with abuse. How about for you? OR Sometimes abusers have a mental illness. Was this the case with your abuser? Many women develop symptoms of mental illness as a result of trauma or abuse. (give examples)*

Questions and information are to be sensitive, relevant and optional - women are invited, not required, to give information, make connections, or consider options. Their comfort level determines the agenda, depth and pace. If they do not wish

to discuss substance use or mental health issues directly, explore other ways to reduce harm and increase safety (Parkes, 2007b).

Implications for Screening, Intake and Assessment

Accurate screening and identification are important tools to ensure clients receive effective intervention and empowering options that meet their needs (Bland, 2008). They are meant to enhance women's safety and ensure appropriate service, not to 'diagnose,' label, or judge, nor to seek reasons to exclude or impose arbitrary expectations. Using them any other way constitutes a misuse of power that not only compromises women's safety and autonomy, but further disempowers and revictimizes them. It is also contrary to transition house goals and mandate.

Domestic violence, substance use and mental health issues often appear together. Therefore screening, intake and assessment are to be informed by, and approached with, the assumption that women who seek shelter from violence are highly likely to also have either substance use or mental health issues. Further, they are to be approached with the intent of improving services and enhancing women's safety through inclusion, not exclusion. In order to support women effectively, it is important to determine not just the presence of substance use or mental health issues, but also the extent to which it affects a woman. This affects not only the support that may be needed, but also the expectations, referrals, information and other services women may need.

<u>Screening</u>

In general, the main function of screening is to determine eligibility for service and to ensure clients receive appropriate support. Standard procedures that screen universally for violence are to be expanded to screen universally for substance use and mental health issues. As with violence, the underlying intent is safety and inclusion, not exclusion. Before beginning the screening process for substance use or mental health issues, staff is to:

- Inform the woman of agency policy regarding substance use/mental health issues in the house and the agency goal of providing an environment of safety and sobriety; be clear that you are asking about these issues not as a basis for denying services, but in order to best plan for her safety and sobriety;
- Explain the reasons behind your questions and inform her of specific consequences for disclosure and the reasons behind them; likewise with policies regarding MCFD involvement.
- Affirm the woman's survival skills and praise her sincerely for finding ways to cope with her situation;

Once these issues are clarified, staff can apply the appropriate screening tools to determine whether or not substance use or mental health issues are a factor and to what extent. The degree to which they are a problem for a given woman is a factor in both her safety and the support she will need;

1. If screening indicates either may be factor, discuss safety issues with her; this may include inviting women to explore ways in which her substance use or mental health issues may affect her safety or how her behaviour could cause difficulties for her, our agency or others;
2. If substance use is the primary issue, inform her that chemicals affect the brain and body whether or not addiction is present; for either issue, discuss options and alternative coping strategies to replace her current ones during her stay (based on Bland & Edmund, 2008).

Screening is only as effective as the context of openness and trust in which it is conducted. Unless they feel safe, women may be reluctant to disclose. Their fears of negative consequences for disclosing problematic substance use or mental health issues are, unfortunately, realistic, and can range from denial of service, loss of children, or forced treatment. Such

fears and the lack of disclosure they result in can limit the usefulness of screening unless it is conducted with acceptance and sensitivity.

Sample screening questions

Screening for Substance Use

- Many women experiencing violence use alcohol or drugs as a way to cope. Have you used either of these in the past month? If so, what & how much?
- Do you have an addictions counsellor you see regularly?
- Does your substance use affect your safety? How? What do you do to try to keep safe? What support would be helpful?
- In what ways could your substance use cause problems for you, the TH or others?
- We need to ensure the safety of all our residents so we have a policy that residents not use substances while staying in the transition house. Will this be difficult for you? Is there anything we can do to help?

Screening for Mental Health issues

- Many women experiencing violence also experience mental health issues. Have you been diagnosed with a mental illness by a qualified professional? If so, what?
- Do you have a MH worker you see regularly? Have you ever been hospitalized for a mental health-related illness?
- Does your mental illness affect your safety? How? What do you do to try to keep safe? What support would be helpful?
- We need to ensure the safety of all our residents. In what ways could behaviour related to your MH issues cause problems for you, the TH or others? (eg aggression; paranoia; difficulty concentrating or thinking logically; seeing/hearing things when no one is there? Is there anything we can do to help?

Intake

If initial screening suggests substance use or mental health issues may be a concern, staff is to follow up during intake by:

1. Introducing substance use or mental health issues and letting them know these are common responses to abuse or violence and can happen to anyone; it may be helpful to lay the groundwork for future conversation with an introductory statement like (Parkes, 2007d):
   A lot of women find themselves increasing their substance use (or experiencing a worsening of mental health problems) when in crisis. We are committed to working with women who have substance use (or mental health) problems here, so please feel free to talk about it if you have concerns. This will not jeopardize your access to services. In fact, it will help us to be more effective in helping you as you work at improving your safety and making decisions.
2. Informing them about alcohol and drug/suicide/self-harm agreements and inviting them to support their own recovery by signing an agreement and adhering to it during their stay.
3. Collaborating with them in developing a safety plan that includes relapse prevention, support group attendance and/or medical attention; the safety plan should also specify triggers, alternative coping strategies, and ways in which staff can support her.
4. Ensuring all staff is aware of their safety plans and how they can best support their choices and enhance their success.
5. Providing them with information about community-based treatment and support options and/or those available in-house; if they want detox or treatment, refer them to the appropriate resources and make the necessary follow-up to support them through the process.
6. If relevant, explaining their legal rights, informing them how to contact the police and what they can expect from a police response; if they prefer not to call the police, discuss other options.

7. If they have children, advising them of parenting behaviours that are considered 'reportable;' make it clear that substance use or mental health issues in and of themselves are not a mandatory reporting issue, but specific behaviours are; also, do not discuss these issues when their children are present, meeting separately with them to assess their needs.
8. Reassuring them that the transition house will always support their efforts.

While completing intake, observe women's appearance, demeanour and behaviour, watching for signs that suggest substance use or mental/emotional status. Does the woman seem exceptionally agitated, anxious, over-excitable, depressed and withdrawn, tearful? What might this behaviour or emotional state indicate? What approach does it suggest taking with them? If warranted, probe for more information about what you observe; if not, continue with standard intake procedures that ask generically about substance use and mental health issues.

The chart below lists cues that may indicate mental health problems, mental distress (Parkes, 2007d), or substance misuse (Bland & Edmund, 2008). Bear in mind, however, that our role is not to diagnose nor is it to punish, and that some of these behaviours are also common among women who are in crisis or are experiencing trauma symptoms or sleep deprivation, or have disabilities or health issues, such as brain injuries. In addition, some behaviours associated with substance use resemble those associated with mental illness and vice versa, so be tentative and cautious and avoid assumptions.

<u>Substance Misuse</u>
- Odour of alcohol on their breath
- Red eyes; pinpoint or dilated pupils
- Track marks on arms, hands or feet
- Inflamed, eroded nasal septum
- Scratching and picking at arms or face during the visit
- Cigarette burns (may also indicate violence or self-harm)
- Difficulty tracking information
- Rapid speech
- Lethargy (may also indicate depression)
- Nodding
- Prescription drug-seeking behaviour
- Distorted perceptions

<u>Mental Health Issues</u>
- Being emotionally high or low in ways that seem out of context
- Being nervous, panicky or suspicious/hostile beyond what is appropriate for the circumstance
- Being hyperactive, unable to sit still or concentrate, or very impulsive and quick to react
- Being withdrawn and very inactive, with slowed down speech and movement
- Lacking coherence or clarity in speech (eg bizarre statements, incoherent ideas, hallucinations)
- Inappropriate facial expression for the context or situation; unusual gestures or postures
- Rapid speech; jumbled up thoughts
- Inability to remember things, use judgment or problem solve
- Disorientation or dissociation
- Unusual dress or appearance; very poor hygiene

Some sample intake questions:
<u>Substance Use</u>
- What substances do you use? How much/often, when, how? Do you use more than one at a time?
- Would you like some information about substance use? If so, what information would be helpful?
- How does your substance use affect your safety or people around you?
- Does your partner use your substance use to harm or control you? (offer examples)

<u>Mental Health Issues</u>
- How would you describe your current emotional

state/state of mind? How does violence affect it?
- Do you ever think about committing suicide? Have you tried before? Do you think about it now? How would you go about it? Do you have a plan?
- Does your partner use your diagnosis to harm or control you? How?
- How does your diagnosis affect your life and behaviour? How does it affect others?

Assessment

Unlike initial screening and intake which are brief and specific, assessment is ongoing, broad and comprehensive. In order to engage in honest, meaningful discussions about their substance use or mental health issues, women need an emotionally safe context (Poole & the Coalescing Virtual Community, 2007), and in-depth exploration of these sensitive issues is inadvisable until after the initial crisis is over and a safe, trusting relationship has begun to develop. Ongoing assessment allows staff to respond to women's changing needs and readiness. Assessment may involve the following:

1. Collaborate with the woman in developing an ongoing support plan to keep up with the actions she chose for her safety and sobriety, for example if/when advocacy is desired, making important calls or a reminder plan for appointments with other professionals/agencies
2. If she relapses and wants to keep working on her goals, invite her to sign the same agreement again; explore and incorporate strategies to improve her chance of success
3. If there are outstanding legal issues stemming from substance use or mental health issues, help her address them by providing advocacy as desired, helping her get the information she needs, or contacting the necessary services
4. Discuss her progress and changing needs for support, seeking feedback about staff responses.

Sample assessment questions (see Appendix E for assessment guidelines and tools):

<u>Assessment Questions for Substance Use</u>

- Are you interested in discussing your substance use or exploring its links with violence?
- Have you ever thought you should cut down? Do you want to make changes in your substance use? What kind of changes and what timeframe do you hope to achieve them in?
- Are the changes you want to make and the timeframe achievable and realistic?
- Do you have the tools to create or cope with these changes? What support, resources or services do you need to make these changes?
- What are the barriers to making these changes? What will help overcome them?
- What makes you start or stop using?
- When you were not drinking or using drugs in the past, what helped you cope? Can you do that now?
- Why do you think it might not be safe to use when someone is being violent towards you?
- How might your use and/or abuse affect your safety? Parenting? Housing? Court? Etc.

<u>Assessment Questions for Mental Health issues</u>

- How would you describe your predominant mood? Is this a change? If so, in what way? When did it change?
- Have you had any difficulty falling/staying asleep? How is your appetite? Your concentration?
- Do you worry a lot? Feel tense, fidgety or on edge? Have difficulty relaxing?
- How do you see the future? Do you have goals?
- Do you ever seem to hear/see things others don't?
- Have you ever felt 'unreal,' like you were not a person, not in the living world? Or that the world around you was unreal?
- Have you ever harmed yourself or thought about harming yourself? How? What makes you do it?
- How might your mental health issues affect your

safety? Parenting? Housing? Court? etc
- Would you like information about the mental health issues you are experiencing? If so, what kind?
- Have you ever been violent? Where is your violence directed?

Reasons for Exclusion from Service

Excluding women from services may be placing them in danger, especially if substance use or mental health issues are involved. Alone, each is insufficient reason for excluding women from service, regardless at the stage of service. Refusing admission or eviction must be based on women's actual behaviour, not their 'label,' and reasons must be based on specific behaviours that are both clearly defined and seen as a potential risk for the agency or other clients. If exclusion seems necessary, it is vital that the woman has other safe options for support or accommodation that she can access. Help in accessing them is to be provided if necessary. The woman must be given a clear explanation for her refusal that states the concrete, specific behaviours on which concerns are based and criteria for future admittance. She is also to be reassured that the refusal is situation-specific and will not affect future requests for admission; service will be available to her another time. (see Appendix C for exclusion guidelines)

Example: if a woman admits she is drunk, high, or actively psychotic and her resulting behaviour is erratic or otherwise inappropriate for the transition house, rather than admitting her, she may be provided with transportation to a hotel or the hospital; reasons for her refusal are to be clearly explained citing concrete behaviours with reassurances of future access.

Dealing with Anger, Hostility or Violence

As a natural, basically automatic response to physical or emotional pain (Welch, 2007), anger is a "natural consequence of trauma, where physical, emotional, spiritual and/or sexual integrity is attacked or compromised" (p. 220; Welch, 2007). Anger itself is neither good nor bad. As just one of many emotions, it is not only healthy and neutral, but also serves a life-preserving function by signalling potential danger or harm and motivating protective action. However, if expressed or acted on inappropriately, anger can have enormous costs on emotional, mental, physical and spiritual well-being, including expulsion from transition houses. Healthy expression is a skill that must be learned.

Like substance use and mental health issues, some degree of anger can be expected in those seeking transition house services. Given the effects of trauma, they can also be expected to have some difficulty regulating their emotions, particularly anger and rage, and as a result may vacillate between emotional numbness and intensity. When intense, emotions can trigger substance use, mental health behaviours, or potentially aggression, which then place women at risk for various harms. Learning to manage and express overwhelming emotions like anger in a healthy way is an important aspect of safety, and therefore also an important service goal.

A harm reduction approach to anger is similar to that with substance use or mental health issues: identifying triggers, subsequent actions, and consequences; developing new ways to respond and express it; linking it to past and present life experiences; and placing it in its social context. With anger, an additional aspect is helping them increase their tolerance for the emotion itself and overcoming the internalized social taboos against women feeling or expressing it. (See Appendix F for more information on Anger)

Implications for Safety Planning

Abuse, substance use and mental health issues affect each other reciprocally, not only in compromising women's safety but also their capacity to protect themselves. Abuse aggravates problematic

substance use and mental health issues, which also increase abuse. Substance use and mental health issues directly affect women in ways that further increase their risk, for example their ability to effectively cope, respond or advocate for themselves. Directly or indirectly, women's safety is at risk due to any one or any combination of these issues. Safety planning must therefore recognize the limitations to autonomy inherent in abuse and how that affects women's ability to seek help or change. In addition to considering how substance use or mental health issues interact with the dynamics of abuse, it must also consider their various direct effects that can compromise women's functioning. For example, women may have difficulty with:

- accurately assessing a situation; they may underestimate potential danger or overestimate their ability to deal with it;
- believing they deserve or will receive help;
- interacting effectively with service providers;
- recalling or acting on steps of an established safety plan;
- connecting their actions with consequences, including safety;
- understanding, following or remembering complex explanations or instructions;
- recalling details about incidents or how injuries were sustained;
- completing accurate police reports or testifying;
- remembering police reports or court dates;
- interpersonal or parenting skills.

While women may need help with developing, remembering or implementing safety plans, they are nonetheless to direct both the process and the final product. When introducing safety assessment and planning, explain their purpose and invite women's participation and emphasize that their decisions are paramount. Above all, it is an option. Women are free to have a plan or not, to act on it or not, or to have it written down or not, and, if written, to decide how it well be kept safe from the abuser. Both the content and format of a safety plan must reflect their choices and unique needs, strengths and circumstances. (Parkes, 2007e).

Since safety is both external and internal, both must be considered. External factors include those related to the abuser or other aspects of women's environment. Internal factors are those related to women themselves, especially mental or physical health, including how these manifest in behaviour. Assess not just for risks, but also for strengths; they will be the basis for both safety strategies and skill development.

<u>Abuser Factors</u>

- level of violence; access to or use of weapons
- violent threats, ideation, intent
- escalation of violence or threats
- violations of civil & criminal court orders
- negative attitudes; response to shifts in power & control dynamics
- other types of criminal behaviour or involvement with the justice system
- employment or financial problems
- substance use; mental health problems
- other issues (eg. current emotional crisis, significant life changes, chronic pain, military training)

<u>Other External Factors</u>

- level of personal support
- current housing/living situation
- barriers created by others' attitudes or beliefs
- employment or financial concerns
- availability or responsiveness of services; coordination of services
- provision of information
- child-related concerns

<u>Internal factors</u>

- level of fear
- barriers created by own attitudes or beliefs
- health impacts of abuse
- substance use; mental health issues
- ability to self-advocate or access services
- capacity for regulating intense emotion
- internal triggers for risk-taking behaviour such as substance use or self-harm
- inaccurate perceptions or reasoning; having delusions or hallucinations

- degree of dissociation or depersonalization
- self-esteem or self-efficacy

Safety planning in relation to substance use or mental health issues may include the following elements (based on Bland & Edmund, 2007 and Parkes, 2007e):

Substance Use

- Where do you usually use? What dangers does this location present to you? Is there a safer place you could go to use?
- Who is around when you are using? What dangers do these people present to you? Are there safer people you could use with?
- What can you do when others'/partner's threatening or risky behaviour starts to escalate? Is there someone you trust whom you can call to come and help you when that happens?
- Do you combine drugs? How does that affect your safety? Which do you think is most risky? Is there a less risky one you could use?
- When you have the urge to use, what is going on inside for you? What situations, feelings or thoughts occur just before that? How did you cope with these before you started using? What might help you now?
- What do you think would help keep you and/or your children safer if/when you are using?

Mental Health Issues

- Which strong emotions do you find the hardest to deal with? What do they feel like for you? How do you react when you feel that way? Are there any consequences for reacting that way? What might be a more helpful way to react?
- What situations or thoughts trigger intense or difficult feelings? What helps? What makes it worse? Is there someone you trust who helps? What do they do that helps?
- How does mental health-related behaviour affect your safety? What could you do differently that would improve that? What support do you need for that?
- When you have the urge to hurt yourself, what is going on inside for you? What method do you usually use? Could you talk to someone about it instead, or use a less dangerous method?
- Let's review the safety plan we've developed. Would you like me to write it down? Will you remember it when you are feeling stressed? What would help you remember?

Essential to any safety plan is assessing and planning for suicide or self-harm. Either is a risk to women's safety and must be addressed. Though they appear similar, the intent behind each is different and therefore requires a different response (Parkes, 2007d). Considering killing oneself is an extreme solution to what is perceived to be unbearable emotional pain or circumstances for which there appears to be no other way out. In contrast, self-harm is not about seeking death, but seeking life. It is a way to cope with intense pain or distress, a way to self-soothe and thus prevent further damage or suicide. As such it is a survival strategy. While it can escalate to suicide, death that occurs as a result of self-harm is generally unintended. When working with self-harm, the goal is to move toward increasingly less frequent and less lethal methods while developing new self-soothing skills.

The process of assessment and safety planning can be overwhelming for women. Proceed at a pace they are comfortable with, checking often about the rate and quantity of information being provided. Allow time for processing and integration. Taking notes can help women stay focused and grounded. Safety plans must be concrete, realistic, and immediate with a focus on what, when, where, and with whom, and on women's basic needs, emphasizing self-care, like sleep, exercise, nutrition, positive social support, meaningful work and daily structure (Parkes, 2007e). Strategies should be related directly to women's safety, behaviours and strengths. Once developed, women may need help remembering their safety plans, for example by hearing them repeated consistently or devising methods to remember them. Throughout, demonstrate hope and optimism.

Expectations of Staff

Staff need not become addictions or mental health counsellors, nor police officers who monitor behaviour (Bland, 2008; Bland & Edmund, 2008). However, they must be willing and able to discuss substance use and mental health issues non-critically and knowledgably, as well as be familiar with their role in the dynamics of abuse and with local resources addressing these issues. This may require staff to increase their knowledge about substance use or mental health issues, especially their impact on women, their role in the dynamics of abuse, and their potential impact on service and safety planning. They must also be willing and able to implement harm reduction strategies in accordance with the underlying spirit and philosophy.

To this end, staff is expected to participate in training related to harm reduction, substance use and mental health issues in order to increase their knowledge and competence in the following areas: (note: the term 'relapse 'applies to both substance use and mental health issues)

Creating safety and building trust – acceptance and a non-judgmental attitude are essential for providing the emotional safety women need to honestly face substance use and mental health issues; express genuine care and concern, and avoid criticism, blaming or labelling; validate women's innate dignity and worth, their experiences and their capacity and will to survive.

De-stigmatizing – emphasize that abuse, substance use or mental health issues could happen to anyone (Bland, 2008) and that substance use and mental health issues are 'normal' responses to violence (Parkes, 2007a) that originally served a purpose: to meet personal needs; (Bland, 2008; Kasl, 1992). (see

Raising awareness – link substance use and mental health issues with abuse and other problems in their lives as well as with other forms of social, gender-based violence; provide information about substance use and mental health issues that helps women understand their impact on and effects in their lives, especially health and safety.

Making referrals – provide a range of treatment and support options for substance use and mental health issues; be informed about local resources and their potential risks, benefits or limitations, as well as which are gender-specific (eg conjoint or family therapy; 12 Step groups; expectations of support for partner's recovery) (Bland, 2008); caution women against those that pose risks. (ensure an up to date list of local support & treatment resources is available that identifies pros & cons of each)

Enhancing confidence and hope - foster belief in their ability to improve their own and their children's lives by pointing out and sincerely appreciating their unique, individual strengths and recognizing even their smallest successes; offer choices, respect the choices made, and provide the support needed to achieve success; show how lessons gained in one area can be applied to another.

Understanding substance use and mental health issues – be familiar with their signs and symptoms, how they develop, and their effects on women's bodies, lives and safety; recognize them as responses to violence and understand their role in the context of abuse and that 'hitting bottom' is not a prerequisite for change; offer written material about abuse, substance use and mental health issues that is clear and uncomplicated with a minimum of jargon.

Addressing substance use and mental health issues in safety planning – know how these issues can compromise women's safety both directly and indirectly, and take them into account in safety or service plans; help women identify situations or conditions in which their safety or sobriety are at risk and help them know when, where and how to flee, respond or cope in safer ways; recognize that unsafe persons, places or things that compromise

women's sobriety or mental health can also compromise their safety.

Recognizing 'relapse' as part of recovery – be aware of the role stress and 'craving' can play in triggering 'relapse' (eg abuse; conflicting or multiple expectations; feeling overwhelmed), including the stress of change (eg securing safety); identify and recognize the physical, emotional, cognitive, environmental or other cues that trigger habitual coping strategies (eg self-harm; substance use) and establish a plan for dealing with them by identifying alternate strategies that are less harmful or more effective; above all, support women after relapse.

Providing structure and support – make guidelines and expectations regarding behaviour clear and specific so women know what to expect (eg describe the parenting behaviours that are considered 'reportable'); make all information or instructions clear, simple and straightforward, and be prepared to repeat them calmly and consistently; be familiar with legal and other related systems/issues that contribute to safety problems (eg health, child protection, nutrition); help women gather the necessary documents to obtain the services they need; offer education in parenting and interpersonal skills so they can develop sober relationships; (prepare written material for clients that outline expectations/behaviours with examples)

Enhancing social support – help women identify their social support systems; ask them who can be called for help (eg sponsor, counsellor) and under what circumstances, and ensure these are included in any 'releases of information;' help women enhance their support system by connecting them with other women through gender-based support or treatment groups.

Increased knowledge is helpful, but an accepting, non-critical attitude is essential. Since personal opinions have a profound impact on practice, staff is encouraged to not just seek education, but also to explore their personal assumptions, beliefs and values regarding substance use and mental health issues. One strategy may be to talk to women in recovery about their life and help-seeking experiences.

Staff is also encouraged to become familiar with available material and resources and to seek opportunities to enhance transition house accessibility by recommending potential resources, such as books, videos, recovery workbooks, or posters that contribute to service delivery or education for either staff or clients. When in doubt about a situation, staff is expected to seek consultation or guidance from other professionals by presenting hypothetical examples that do not break confidentiality.

AGENCY RESPONSIBILITIES

[Agency Name] will further enhance the practice of harm reduction in its own services as well as other women's services in the community:

- Develop procedural guidelines and forms to assist staff in implementing harm reduction policies and strategies, including assessing immediate risk to women from substance use or mental health issues in as well as violence, and addressing the impact of these issues on safety planning;
- Prioritize hiring those with personal experience or knowledge in their backgrounds regarding substance use or mental health issues either as employees or volunteers;
- Develop, plan and budget for comprehensive support; regularly monitor or evaluate the plan;
- Recognize that the work of advocating for and supporting victims of violence in an unsupportive economic, social, political context can create considerable frustration and potentially result in systemic trauma (Ziegler, 2007); encourage staff to practice strategies that help mitigate its effects and address the discouragement or disillusionment that can result, like self-care, constructive debriefing, and collective actions

that promote systemic change;
- Assist staff in dealing with their own assumptions, values and feelings regarding substance use and mental health issues;
- Provide ongoing training regarding harm reduction, substance use and mental health issues in order to enhance staff competence and ability to implement harm reduction policies and to:
  - approach women in ways that create safety
  - recognize signs and symptoms
  - make appropriate referrals
  - inform women about potential effects of abuse, substance use and mental health issues;
  - caution women against treatment or support options that pose risks
- Provide cross-training with substance use and mental health service providers to increase awareness in both groups of safety and sobriety issues;
- Provide written materials relevant to abuse, substance use and mental health issues that can be used for educating staff, clients, other service providers and the public;
- Develop on-site support and/or treatment groups for women, both formal and informal;
- Partner with local addictions and mental health agencies to develop tools to identify and address the needs of women and children affected by multiple issues;
- Educate other service providers about
  - the effects of abuse,
  - the impact of the 'standard approach' on domestic violence victims,
  - the potential risks of certain treatment approaches (eg. family or conjoint counselling),
  - the importance of gender-specific treatment.

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REDUCING BARRIERS PROJECT INFORMATION

Original Project Name
"Opening Doors: Reducing Barriers for Women Living with Mental Illness, Substance Abuse, and Violence"

Project Duration
February 9, 2009 – August 8, 2011

Funded By
Status of Women Canada

Objective
To develop a more coordinated approach to services in Transition, Second and Third Stage Houses and Safe Homes for women fleeing violence and who have varying levels of mental wellness and substance use in BC and the Yukon.[i]

BCSTH's Intentions
To encourage our Members to collaborate with each other and other sectors to come up with inclusive policies, procedures and practices that best serve women who are fleeing violence

Important Elements

Working Group
- Comprised of 16 members – women, BCSTH members, representatives from mental wellness and substance use sectors and BC Housing (funder of Transitional Housing programs)

Research
- Review of current challenges and promising practices in BC, Canada and Internationally, summarized in discussion paper which was distributed for feedback throughout Canada
- survey of current policies, procedures and practices in Transitional Housing programs in BC conducted by Arbor Educational & Clinical Consulting Inc
- focus groups and surveys with women about their experiences and recommendations conducted by Woman Abuse Response Program at BC Women's Hospital & Health Centre
- Consultation with Service Recipients about draft Promising Practices

Training & Piloting
- 6 pilot sites from various communities and contexts throughout BC, including Transition House, Second Stage and Safe Home programs
- Up to five staff from each program attend four days of training on the Promising Practices
- Implementation Committee
- Comprised of representatives from various Ministries and Health Authorities
- To filter information to and from the project

End Product
A ***Promising Practices Guide*** that outlines Promising Principles as well as concrete and practical actions agencies can use to ensure their policies, procedures and practices are inclusive of women fleeing violence who also have varying levels of mental wellness and substance use.

A ***four-day curriculum*** based on the Promising Practices guide for front line workers in Transition, Second and Third Stage Houses and Safe Homes in BC and the Yukon.

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i Although BCSTH represents Transitional Housing programs in BC only, at the time of applying for funding for this project we also represented the Yukon and hope that the Promising Practices are relevant for our former Members as well.