THE HARMS OF HELP: EXPLORING WOMEN'S EXPERIENCES WITH ANTI-VIOLENCE, ADDICTIONS AND MENTAL HEALTH SERVICES WITHIN BRITISH COLUMBIA

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ABSTRACT

Despite the intention of the anti-violence, addictions and mental health sectors to enhance women's health and safety, research has revealed that these services can unintentionally cause harm. This qualitative study used focus groups to explore, understand and describe the harms of British Columbia's anti-violence, addictions and mental health services from the unique and varied perspectives of women who have experiences of abuse, substance use and mental health issues. Five themes of service harms emerged. Exclusion from services undermined women's ability to escape high-risk situations; contact with services triggered women's substance use; mistreatment from service providers created a barrier to help-seeking; inattention to women's experiences of abuse made services unreflective of women's needs; and child apprehension directly contributed to mother's use of substances. To eliminate service harms, recommendations are provided for the provision of women-centred care; trauma-informed and trauma-specific services; and the integration of anti-violence, addictions and mental health services.

Keywords: woman abuse; substance use; mental health; addictions; anti-violence; harm; service sectors

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1: INTRODUCTION

1.1 Introduction to the Public Health Problem

Research affirms that women's health is profoundly impacted by abuse, substance use and mental health issues[1] and that the co-occurrence of these three conditions can adversely affect the outcome of each (Becker et al., 2005; Swan, Farber & Campbell, 2001; Thompson & Kingree, 1998). While the strong association between woman abuse, substance use and mental health issues has been established within the literature (Duncan, Saunders, Kilpatrick, Hanson & Resnick, 1996; Goldings, 1999), developing practices and policies that reflect this association has challenged the anti-violence, addictions and mental health sectors (Gatz, Brounstein & Taylor, 2005). Despite the intention of these sectors to enhance women's health and safety, a small, but growing body of research has revealed that these services can unintentionally cause harm (Elliot, Bjelajac, Fallot, Markoff & Glover Reed, 2005; Fallot & Harris, 2001; Frueh et al., 2000; Markoff, Glover Reed, Fallot, Elliot & Bjelajac, 2005; Warshaw, 1997). To advance our understanding of service harms, this paper sought to explore the harmful effects of British Columbia's anti-violence, addictions and mental health services as described by women who have experiences of abuse, substance use and mental health issues.

[1] The term abuse, substance use and mental health issues will be used broadly throughout this paper to encompass the continuum of these three issues as these terms are least stigmatizing.

1.2 Background

In 2006, the Woman Abuse Response Program at BC Women's Hospital launched the *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health* research initiative. The purpose of this initiative was to improve the anti-violence[2], addictions[3] and mental health[4] sectors' response to women who have experiences of abuse, substance use and mental health issues. In 2008, with funding from the Vancouver Foundation, the Woman Abuse Response Program initiated a one-year consultation process to gather evidence to inform a provincial framework to improve services for women impacted by these three issues. During the year, the program facilitated cross-sectoral workshops and conducted individual interviews with service providers from the anti-violence, addictions and mental health sectors. As well, focus groups were conducted among women impacted by abuse, substance use and mental health issues[5] to explore their experiences with anti-violence, addictions and mental health services. This author participated in the *Building Bridges* initiative to fulfil practicum requirements of the Master of Public Health program at Simon Fraser University.

[2] The anti-violence sector includes those services whose primary mandate is to support women who have experiences of abuse, including women's shelters, transition houses, sexual assault services, victim services and other women's advocacy organizations.

[3] The addictions sector includes those services whose primary mandate is to address substance use, including inpatient, outpatient, residential and community-based treatment services.

[4] The mental health sector includes those services whose primary mandate is to address mental health, including inpatient, outpatient, residential and community-based mental health services.

[5] To be included in the focus groups, women had to have experience(s) of abuse and either substance use or mental health issues or both.

1.3 Purpose

The purpose of this project was to use the data collected during the focus groups to explore, understand and describe the harm of anti-violence, addictions and mental health services from the unique and varied perspectives of women who have experiences of abuse, substance use and mental health issues. Within these focus groups, women were not directly asked about service harms; rather, from women's stories when questioned regarding their overall experiences with these three service sectors emerged the harms of services.

Despite the purpose of examining women's negative experiences, this project must be placed within the context of other research which has showed that women's outcomes- including some types of drug use, alcohol use and mental health symptoms- do improve after they engage with anti-violence, addictions and mental health services (Cocozza et al., 2005; Greaves, Chabot, Jategaonkar, Poole & McCullough, 2006). Therefore, the intention of this paper was to provide evidence to support practitioners, planners and policymakers to maximize the benefits of services by assessing and eliminating the unintentional harms that may be present within current service arrangements in BC.

1.4 Research Question

The research question explored within this paper was:

How do women, with past or current experiences of abuse, substance use and mental health issues, describe being harmed by anti-violence, addictions and mental health services within BC?

1.5 Literature Review

1.5.1 Woman abuse

Woman abuse is most commonly defined as:

> 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 acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (United Nations, 1993, p. 3).

This definition emphasizes that woman abuse is rooted in gender inequality and that negative health consequences can result, therefore framing woman abuse as a public health issue. As stated by the definition, a woman's experience of abuse can result in physical (ie. fractures, abdominal/thoracic injuries or gastrointestinal disorders), sexual (ie. gynaecological disorders, unwanted pregnancies or sexually transmitted diseases) and/or psychological harm (ie. post-traumatic stress disorder, anxiety or depression) (World Health Organization, 2002). The greatest contributions to the burden of disease associated with woman abuse are mental health and substance use issues, accounting for 73% and 22% of the total disease burden, respectively (Vos et al., 2006). An expected result of these health consequences is that abused women have higher rates of health care service utilization than non-abused women (Cohen & MacLean, 2004). The annual cost of woman abuse to the Canadian health care system has been estimated to be just over $400 million (Greaves, Hankivsky, Kingston-Riechers, 1995).

A systematic review of sixteen studies, undertaken by the Canadian Public Health Association (2003), estimated that among Canadian women, the annual prevalence of physical abuse was between 0.4% to 18.6% and emotional abuse was between 13.1% to 23.0%. Over a Canadian women's lifespan, the review estimated that 8.0% to 36.4% experienced at least one episode of physical or sexual abuse at the hands of their male partner (Clark & Du Mont, 2003). These numbers likely underestimate the prevalence of woman abuse, a result of underreporting due to stigma, self-blame, shame and fear (Stenius & Veysey, 2005). The wide variance in estimated prevalence rates of woman abuse can be attributed to: (a) definitional inconsistencies of woman abuse, (b) variations in inclusion criteria of study participants, (c) the willingness or ability of women to disclose their experiences, and (d) methodological limitations of the study, such as the way questions are posed (i.e. behavioural-based questioning vs. direct questioning) or the data collection method (i.e. written surveys vs. face-to-face interviewing) (Cohen & Maclean, 2004; World Health Organization, 2002).

1.5.2 The association between woman abuse, substance use and mental health issues

The association between woman abuse, substance use and mental health issues has been well documented across demographic groups and diverse treatment settings (Huntington, Moses & Veysey, 2005). A meta-analysis conducted by Golding (1999) examined the strength of this association. The study revealed that women exposed to physical abuse had statistically significant greater odds of all mental health and substance use outcomes included within

the study. Specifically, the odds of depression (OR= 3.80, 95% CI 3.16, 4.57), suicidality (OR= 3.55, 95% CI 2.73, 4.60), post-traumatic stress disorder (OR= 3.74, 95% CI 2.50, 6.83), alcohol abuse and dependence (OR=5.56, 95% CI 3.32, 9.31) and drug use and dependence (OR=5.62, 95% CI 3.55, 7.72) were greater for abused than non-abused women (Golding, 1999).

In order to understand the nature of the association between woman abuse, substance use and mental health issues, researchers have attempted to establish the temporal ordering of the three. Strong research has been conducted which shows that women's experiences of abuse precede their substance use and/or mental health issues (Gatz, Russell et al., 2005; Humphreys, Thiara & Regan, 2005; Purdon, 2008). At the same time, there is evidence that shows that substance use and/or mental health issues can create a vulnerability to abuse and that the pre-existence of these conditions may exacerbate the effects of abuse (Gatz, Russell et al., 2005; Testa, Livingston, Leonard, 2003). Clearly, the association between these three issues is both complex and multidirectional (Gatz, Russell et al., 2005; Huntington et al., 2005).

Studies across anti-violence, addictions and mental health services have shown that women entering these settings have overlapping experiences of abuse, substance use and mental health issues. Within transition houses, it has been documented that over half of women suffer from major depression (Helfrich, Fujiura, Rutkowski-Kmitta, 2008) and over one third suffer from post-traumatic stress disorder (Street & Arias, 2001). The prevalence of substance use disorders among women in these houses has been estimated to range from 33%

to 86% (Humphreys, Thiara et al., 2005). Within substance use treatment, research has shown that almost two out of five women have a co-occurring major mental health disorder (Havassy, Alvidrez, Owen, 2004), almost two out of three have a history of abuse (Miller, Downs, Testa, 1993; Swan et al., 2001), and almost half are in a currently abusive relationship (Swan et al., 2001). Within mental health services, the overlap between abuse and substance use is also substantial. Among inpatient populations, one study estimated that 83% of women had been exposed to severe physical or sexual abuse as a child or woman (Firsten, 1993). Within community mental health services, it has been documented that almost half of women have a co-occurring substance use disorder (Havassy et al., 2004).

An Ontario-based study revealed that regardless of which sector- anti-violence, addictions or mental health- women facing these three issues were in contact with, each had a similar number of experiences of abuse, substance use and mental health issues (Purdon, 2008). These findings indicate that the types of issues- abuse, substance use or mental health- that women are facing are quite similar, regardless of which sector they engage with (Purdon, 2008).

1.5.3 Challenges to integration across the anti-violence, addictions and mental health sectors

The anti-violence, addictions and mental health sectors are clearly serving women with overlapping experiences of abuse, substance use and mental health issues. This suggests that within these sectors, integration is required to reflect the overlap of these three issues (Humphreys, Regan, River & Thiara, 2005;

Humphreys, Thiara, et al., 2005; Huntington et al., 2005; Markoff, Finkelstein, Kammerer, Kreiner, Prost, 2005). Although integrated services are more effective than non-integrated services for working with this population of women (Amaro et al., 2007; Morrissey et al., 2005), lack of integration across the anti-violence, addictions and mental health sectors has occurred for numerous reasons.

One of the predominant reasons for the separation of services has been philosophical differences between the three sectors. Anti-violence services, which grew out of the women's movement, have historically understood woman abuse to be a socially constructed phenomenon that occurs within the context of women's oppression (Purdon, 2008). Within these services, the empowerment of women is often a guiding principle of service delivery (Humphreys, Regan et al., 2005; Humphreys, Thiara et al., 2005; Morrow, 2002; Purdon, 2008). In contrast, addictions and mental health services have primarily worked from a gender-neutral perspective, meaning that the role of gender may be undervalued in understanding women's experiences (Humphreys, Regan et al., 2005; Humphreys, Thiara et al., 2005). Furthermore, within addictions and mental health services, the medical model, which often emphasizes pathology over strengths (Humphreys, Regan et al., 2005; Humphreys, Thiara et al., 2005; Swan et al., 2001), diminishes the role of abuse in disease aetiology (Morrow, 2002), and reduces complex social problems to treatable diagnoses (Warshaw, 1997) is predominant. However, variations of and challenges to the medical model are

present among and between the addictions and mental health sectors (ie Peele, 1985).

Priorities between the three sectors also differ. In general, anti-violence services are primarily concerned with women's safety, addictions services are concerned with sobriety or harm reduction, and mental health services are concerned with mental stabilization. Often, there is little consideration that attending to a woman's "other" issue(s) will affect success in treating her "primary issue" (Swan et al., 2001).

Despite these differences across sectors, efforts towards integration have occurred within BC, especially in regards to the mental health and addictions sectors. Recognizing the overlap between these two issues, all six provincial health authorities within BC have amalgamated mental health and addictions services and promising programs that provide integrated treatment to women with concurrent disorders have been established. However, systematic efforts to integrate services that address women's experiences of abuse have been slower. For example, Morrow (2002) stated that within BC, there are few programs that meet the needs of women who have experiences of abuse and serious mental health problems. Yet, promising projects, such as the Maxxine Wright Community Health Centre, show that progress towards integration within the province is slowly being made. Based on a unique partnership between Fraser Health Authority, Atira Women's Resource Society, the Ministry of Children & Family Development and Options BC, the Maxxine Wright Community Health Centre provides wraparound services to expectant mothers and mothers of

children under the age of two who are impacted by substance use and/or abuse within a single health unit (Atira Women's Resource Society, 2006).

1.5.4 How the association between woman abuse, substance use and mental health issues affect women's interactions with services

Perhaps the most comprehensive analyses of how these three issues affect women's interactions with services have come from London's Stella Project, which examined anti-violence and addictions services' response to victims and perpetrators of domestic violence who use substances (ie. Humphreys, Regan et al., 2005; Humphreys, Thiara et al., 2005; Stella Project, 2008) and the United States' Women Co-Occurring Disorder and Violence Study (WCDVS), which examined addictions and mental health services' response to women who have co-occurring experiences of abuse, addictions and mental illness (ie. Becker et al., 2005; Markoff, Glover Reed et al., 2005; Stenius & Veysey, 2005). Yet, strong research has also been conducted within BC (ie. Bennett & Sadrehashemi, 2008; Morrow, 2002; Poole & Issac, 2001) and other Canadian provinces (ie. Purdon, 2008) that provides insight into women's experiences with local service arrangements. Therefore, both sources of data were used to understand how the association between abuse, substance use and mental health issues affect women's interactions with services.

Research has consistently shown that too often, when these women reach out to services, they are turned away because of exclusionary policies across the anti-violence, addictions and mental health sectors (Humphreys, Regan et al., 2005; Najavits, 2007). These policies, in which a woman's use of substances

may be used to turn her away from mental health services until she can achieve sobriety, or a woman's mental illness may be used to turn her away from refuge until stabilized, mean that women in need are not receiving services (Humphreys, Regan et al., 2005; Najavits, 2007). Instead, these women are excluded because one or more parts of their lives do not fit (Humphreys, Regan et al., 2005; Markoff, Glover Reed et al., 2005). For example, Morrow's (2002) survey among BC anti-violence service providers[6] revealed that while women with mental health issues frequently requested their services, these women's requests were often granted only if specific conditions were met. Conditions for services included that the woman be sober, that the woman be capable of independent living and/or that the woman not be a threat to other service consumers (Morrow, 2002).

For mothers, contact with anti-violence, addictions and mental health services can mean risking losing custody of their children, creating a seemingly paradoxical situation (Bennett & Sadrehashemi, 2008; Poole & Issac, 2001). On the one hand, these mothers rely on services to attend to their own and their children's needs (Bennett & Sadrehasemi, 2008). On the other hand, contact with services may result in mothers coming under the scrutiny of the Ministry of Children and Family Development (MCFD), which ultimately could lead to the apprehension of their children (Bennett & Sadrehasemi, 2008). Many mothers deem the risk of apprehension as too high and therefore, may not access the help they need (Bennett & Sadrehasemi, 2008; Poole & Issac, 2001). Mother's

[6] Including service providers from transition houses, women's centres, victims services and sexual assault centres

fears of losing their children are incredibly real for this population of women. In one study among women with co-occurring experiences of abuse, substance use and mental health issues, almost three quarters reported that they had lost custody of their children within the last six months (Becker et al., 2005). When these women engaged with services, less than two out of five reported that they were provided services that supported them in fulfilling their role as a mother (Becker et al., 2005).

For those who do successfully enter services, research has shown that in comparison to women with either condition alone, women who have experiences of abuse, substance use and mental health issues have worse treatment outcomes (Comfort & Kaltenbach, 2000; Swan et al., 2001; Thompson & Kingree, 1998). For example, Swan et al.'s (2001) study showed that women living within an abusive relationship were significantly less likely to complete substance use treatment; only 41% of women who were currently in an abusive relationship completed treatment, compared to 77% of women who were not in an abusive relationship.

Women who remain in services are often forced to enter settings that focus on narrowly defined problems, rather than being able to address themselves as a whole (Stenius & Veysey, 2005). When services address only one problem- either abuse or substance use or mental health issues- at anytime, one or the other issue(s) becomes secondary and the opportunity to address all three issues together is lost (Humphreys, Regan et al., 2005; Humphreys, Thiara, et al., 2005). Because of this, many women report that they have unmet

treatment needs (Becker et al., 2005). For example, among women receiving substance use treatment, only 25% stated that their experiences of abuse were adequately addressed (Swan et al., 2001). Service providers may be reluctant to acknowledge women's experiences of abuse, either viewing it as a distinct issue in itself or may diminish its significance due to fear or misperceptions, concerns that addressing abuse is counter-therapeutic, lack of appropriate and specialized programs, or insufficient knowledge and training (Morrow, 2002). An Ontario-based study revealed that 40% of mental health service providers and 37% of addictions service providers reported fair or poor competence levels in dealing with abuse (Purdon, 2008). As well, 33% of anti-violence workers reported fair or poor competence levels in dealing with both substance use and mental health issues (Purdon, 2008).

When women's experiences of abuse are unacknowledged, their sufferings are made invisible, their experiences of being silenced are reinforced, their needs are unmet and important aspects of their being are invalidated (Health Canada, 1999; Humphreys, Regan et al., 2005). Furthermore, by discounting women's experiences of abuse, women's needs for safety have often been undervalued (Hennessy, 2004). By not attending to these issues, services are placing the onus on women to address the abuse and ensure their own safety, with little to no support (Cory & DeChief, 2007). Not surprisingly, many women find that they are reluctant to engage with services that do not support them with these issues early in treatment (Markoff, Glover Reed et al., 2005).

1.5.5 Harm of services

Despite the intention of the anti-violence, addictions and mental health sectors to enhance women's health and safety, a small, but growing body of research has revealed that these well-meaning services can unintentionally cause harm (Elliot et al., 2005; Fallot & Harris, 2001; Frueh et al., 2000; Markoff, Glover Reed et al., 2005; Warshaw, 1997). The bulk of theorizing in this area has suggested that clinical encounters can cause retraumatization among women who have experiences of abuse and associated trauma. Too often, services can be retraumatizing by replicating the events or dynamics of women's primary trauma (Elliot et al., 2005; Markoff, Glover Reed et al., 2005; Warshaw, 1997). Retraumatization occurs when services fail to recognize the trauma in women's lives, thus making services invalidating, disempowering and unsafe (Elliot et al., 2005; Markoff, Glover Reed et al., 2005; Warshaw, 1997). Retraumatization can occur in numerous ways, such as by use of seclusion, restraints or involuntary medication (Markoff, Glover Reed et al., 2005). However, it can also occur in more subtle ways. For example, confrontational or aggressive techniques that may be used to break down a women's denial of her substance use can be retraumatizing in that such an approach parallels the interpersonal dynamics of a women's abusive relationship (Markoff, Glover Reed et al., 2005; Swan et al., 2001; Warshaw, 1997). Within BC, some promising initiatives, such as Riverview Psychiatric Hospital's development of a staff-wide training program to avoid retraumatization, have been initiated although not sustained (Morrow, 2002).

Beyond retraumatization, research interrogating standard practices, such as universal screening of women for abuse, has revealed that such practices are potentially harmful, particularly for abused women (Gielen et al., 2000). In general, the purposes of screening are two-fold: to detect positive cases and to provide efficacious intervention to those in need, thereby reducing morbidity and mortality (Harris et al., 2001). Some implicit assumptions that underlie recommendations for screening include that screening is safe, acceptable and that it results in the provision of positive interventions, which improve the screened persons health and well-being (Ramsay, Richardson, Carter, Davidson, Feder, 2002). Benefits of this seemingly intuitively appropriate practice have been documented, such as that screening demonstrates to women that someone is interested, that they are not alone, that they can talk about abuse and that it makes it easier to get help (Garcia-Moreno, 2002; Gielen et al., 2000).

Yet, little evidence exists to suggest that screening results in positive changes to important outcomes, such as women's safety (Ramsay et al., 2002). Furthermore, Gielen et al.'s (2000) case-control study among abused and non-abused women revealed the troubling finding that screening for abuse could compromise women's safety, wherein 39.6% of abused women expressed that being screened for abuse would place them at more risk of being hurt by their abuser. As well, the acceptability of screening was low among women impacted by abuse, with almost 50% stating that they would be embarrassed or offended if screened for abuse (Gielen et al., 2000).

Despite women's expressed concerns and fears, some organizations within BC continue to advocate for universal screening. For example, within Vancouver Coastal Health, policy is in place for screening, however it is inconsistently applied throughout the health region (J. Cory, personal communication, March 31, 2010). Within BC Women's Hospital, which falls under the Provincial Health Services Authority, a women-centred, violence-informed approach is used, which recognizes the potential harms of screening (Cory & Dechief, 2007).

Empirical research conducted within the mental health sector, specifically inpatient psychiatric services, has also documented service harms. Within this body of research, Frueh et al. (2000) conceptualized the harm of psychiatric services, identifying them as "sanctuary trauma" and "sanctuary harm". The researchers defined sanctuary trauma as an event which met the diagnostic criteria for a traumatic event; that is the person "experienced, witnessed or was confronted with an event or events that involved or threatened death or serious injury or a threat to the physical integrity of self or others", and their response to this event involved "intense fear, helplessness or horror" (Frueh et al., 2000, p. 150). The authors conceptualized the term sanctuary harm to include those events, which did not meet the diagnostic criteria for a traumatic event, but were nonetheless "distressing, frightening, humiliating, and/or highly insensitive... and which may result in new or exacerbated psychiatric symptoms and/or reduced participation in later mental health treatment" (Frueh et al., 2000, p.150). By conceptualizing sanctuary harm, the researchers intended to uncover the

adverse psychiatric effects of harmful events that may typically go unnoticed (Frueh et al., 2000).

To explore these concepts, the researchers randomly selected psychiatric patients, including both men and women, to participate within their study. The data showed that a high percentage of patients reported a traumatic event within the psychiatric setting over their lifetime, including experiencing a physical assault by either a staff (13%) or a patient (26%), a sexual assault by either a staff (8%) or patient (8%), or witnessing a traumatic event (63%), such as a physical assault, sexual assault or death. The percentage of patients that reported potentially harmful events was also high, including being around patients who were violent or frightening (54%) or experiencing name-calling from staff (26%). Additionally, the researchers revealed that many patients were exposed to highly coercive measures, including handcuffed transport (65%), use of seclusion (59%), restraint (39%), takedowns (29%) and involuntary medication (27%). For many patients, especially for those with histories of sexual or physical abuse, such events resulted in prolonged psychological distress (Frueh et al., 2005).

To further understand sanctuary harm within the psychiatric setting, the researchers conducted semi-structured qualitative interviews with psychiatric patients. Of the twenty-seven participants included within the study, eighteen reported a harmful experience, which was understood to be related to one of two broad themes. The first theme related to the hospital setting, with patients disclosing the sanctuary harm of the hospital feeling inherently unsafe, as well as

the arbitrary nature of hospital rules. The second theme related to negative interactions with clinical staff, including impersonalized treatment, lack of fairness and disrespect. Overall, sanctuary harm resulted in patients exiting treatment feeling humiliated, uncared for and unsafe (Frueh, 2005; Robins, Sauvageot, Cusack, Suffoletta-Mairerle, 2005). While these findings are specific to the psychiatric setting, they do suggest that lack of safety and negative relationships with service providers may be potential sources of service harms.

2: METHODS

2.1 Study Population

Community partners working in the anti-violence sector within the province of BC recruited focus group participants. Purposeful sampling was used to select women who had experiences of abuse, substance use and mental health issues. This method of sampling was appropriate to select especially informative participants who met a highly specific inclusion criteria (Neuman, 2006). To be included within the study, participants had to: (a) self-identify as a woman; (b) be nineteen years of age or older; (c) have past or current experience(s) of abuse, including, but not limited to physical, sexual, emotional, financial, social or cultural abuse, perpetrated by, but not limited to a partner, family member, stranger, pimp or residential school; (d) have past or current experience(s) of either substance use or mental health issues or both; and (e) have received support, currently or in the past, for their experience(s) of abuse. All participants provided written informed consent.

2.2 Data Collection

Focus groups were facilitated by staff from the Woman Abuse Response Program and this author. A semi-structured interview schedule [Appendix] guided group facilitation, which asked women to explore three broad questions,

including: (a) How they experienced the links between abuse, substance use and mental health issues? (b) How they experienced accessing anti-violence, addictions and mental health services? (c) What improvements would they recommend for anti-violence, addictions and mental health services to better support women who have experiences of abuse, substance use and mental health issues? For their participation, women were provided with an honorarium, childcare subsidy and bus tickets.

2.3 Methodology

A qualitative research approach was used within this study. This form of inquiry employed an exploratory and inductive approach, which aimed to develop a detailed description of women's experiences with services (Creswell, 2009; Morrow, Hankivsky & Varcoe, 2007). Specifically, focus groups were used as they offered a valuable methodological tool to "explore issues relevant to person-in-context" (Wilkinson, 1998, p. 112). Rather than isolating women from their social context, focus groups provided a supportive environment for women to discuss their experiences, to overcome isolation, to realize commonality between their experiences and others, and to understand that their personal experiences have social, rather than solely individual causes. The use of focus groups also supported a more egalitarian-based data collection process by reducing the power and control held by the group facilitators (Wilkinson, 1998).

Feminist standpoint theories offered the importance of situating knowledge in the lived experience of women (Naples, 2007). Feminist standpoint theories posits that:

> It is a woman's oppressed location within society that provides [her with] fuller insights into society as a whole; women have access to an enhanced and more nuanced understanding of social reality than men do precisely because of their structurally oppressed location vis-á-vis the dominant group (Nagy Hesse-Biber, 2007, p. 10).

Since oppressed populations must know both their own and their oppressor's social context, whereas oppressors must only know their own context, that the perspective the oppressed provides a greater picture of the social world (Nagy Hesse-Biber, 2007). As women participating within the focus groups had lived experiences with anti-violence, addictions and mental health services, their unique and situated knowledge provided a way of building evidence about service harms.

2.4 Data Analysis

All focus groups were audio recorded, transcribed to intelligent verbatim[7], and analyzed using open and axial coding (Neuman, 2006). Several compelling broad themes emerged from our analysis; however, this paper focuses exclusively on the harms of services. This author conducted an initial review of the focus group transcripts to locate all data related to service harms. Repeated observations were identified within these data and were collated into themes, each having a number of related subthemes. Comparisons and connections were made across themes and subthemes, coding labels were applied and quotations were selected to illustrate key points. Themes were included based

[7] Intelligent verbatim transcription means that irrelevant words or sounds were eliminated and grammar was corrected

on two criteria: (a) the frequency in which the theme arose across groups and; (b) the magnitude of harm experienced, meaning that when women suggested they experienced a high level of harm, these data were included.

Ethical approval was granted to the *Building Bridges* project by the UBC Children's and Women's Research Ethics Board and the Fraser Health Research Ethics Board. Specifically for this paper, ethical approval was also obtained from the Research Ethics Board at Simon Fraser University.

3: RESULTS

A total of nine focus groups and two individual interviews were conducted among seventy-six women, with representation across all five provincial health authorities [Table 1]. In Squamish, individual interviews were conducted instead of a focus group because only two women attended and they indicated a preference to be interviewed individually due to the small group size.

Table 1.1

Number of Participants by Health Authority

Health Authority	Location	# of Participants
Northern Health Authority	Prince George	6
Interior Health Authority	Creston	8
	Kelowna	11
Fraser Health Authority	Surrey	12
Vancouver Island Health Authority	Victoria	17
Vancouver Coastal Health	Vancouver Downtown Eastside	16
	North Vancouver	2
	Powell River	2
	Squamish	2
TOTAL		**76**

The participants within this study represented a group of highly diverse women, in regards to their age, race, ethnicity, immigrant status, abilities and other forms of social difference. Yet, the experience of low socioeconomic status was seemingly shared among many women, revealed through disclosures of experiences of poverty, deprivation, homelessness, unemployment and being on welfare.

Overall, five themes of the harms of services emerged. The first theme was that exclusion from services undermined women's ability to escape high-risk situations. Second, women's contact with services triggered their substance use. Third, mistreatment from service providers created a barrier to help-seeking. Fourth, inattention to women's experiences of abuse made services unreflective of women's needs. Lastly, child apprehension directly contributed to mother's use of substances.

3.1 Service Harms

3.1.1 Exclusion from services undermined women's ability to escape high-risk situations

Many women disclosed that they were turned away when they sought services from the anti-violence, addictions and mental health sectors. Often, the grounds for denying women access to these services were the "other" issue(s) in their lives. Program mandates[8], which did not reflect the association between woman abuse, substance use and mental health issues, were repeatedly

[8] Program mandates commonly specify: (a) the population of client's served by the program (ie. women-only), (b) the type of services provided by the program (ie. abstinence-only services), and (c) the length of time services will be provided by the program (ie. up to 30 days in transition homes)

identified as contributing to women's exclusion from services. Jana[9], a woman diagnosed with bipolar disorder, explained that she was excluded from transition house services because of her mental health status. She stated, " I ended up phoning one [a transition house] . . . and they had decided not to take anymore bipolar patients." Mandates that limited the provision of services to women who were abstinent were identified as particularly problematic and were most often cited to be present within shelter and transition house services. When these types of mandates were present, women disclosed that they would deceive service providers of their substances use in order to access or remain in services. Because of this deception, women recognized that they would not receive support to address their active substance use, as illustrated by Jenn in stating:

> You go to a place where you're trying to be safe and you're lying to the people that are trying to help you. When I stayed at the transition house, I was messed up. I was still using. There was no way that I could tell them that. So you don't get to address the issues to stop using.

When women were honest about their "other" issue(s), they risked being excluded from services. Barb explained that after being turned away multiple times, she resigned to remaining in her current circumstances. She recalled:

> One time I was suicidal and on drugs . . . I went to the hospital. Because I was suicidal, I couldn't go into detox . . . Because I was on drugs they wouldn't put me on the psych ward. So they said "go". You've got to be

[9] Pseudonyms are used throughout this paper to protect women's identity

fucking kidding me. Do you know how long it's taken me to get there? So I stayed on an unhealthy path for a lot longer.

Liz explained, "Women get fed up. They try and get help and they just get fed up and don't try anymore. They just give up asking for help."

Women also identified being excluded by programs that specified the termination of services after a designated amount of time. These timelines were most commonly identified as being present in transition houses, which limited the total number of days women could stay, or in addictions and mental health services, which capped the total number of visits with counselling professionals. When services were terminated prematurely, women identified that they were placed at risk of returning to their prior circumstances. For example, some women discussed having no alternative but to return to an abusive situation once transition house services were terminated, as revealed by Betty's comment, "I saw a couple people go back to the abusive relationship because they had no other options. They could only hold them for so long." Shelley, a woman who was with her abusive partner for five years, disclosed that once she had exceeded the amount of time she was able to stay at a transition house, she returned to her partner to suffer the most severe physical assault ever. She recalled, "I had already been in one transition house and I had nowhere to go. So I ended up going back . . . That's when he went crazy, broke my arm, came flying at me and kept hitting me. He had his arms around my throat." Later on in the conversation, Shelley stated that she believed her partner would have killed her that night had her neighbours not called the police.

Women also commonly stated that they had to "hit rock bottom" before services, particularly mental health, would no longer exclude them. This point was suggested by Melody in stating, "I mean I had to be a basket case before the help was presented to me. I mean when you get it [services] it's great, but you have to be literally broken before you do". Many women spoke of the suffering they endured in waiting to become "crazy enough" to become "a priority" for the mental health system.

3.1.2 Contact with services triggered women's substance use

When women were able to successfully enter services, many identified that this contact risked their sobriety. Women disclosed that other service consumers, particularly in transition houses, were actively using substances and exposure to their substance use was triggering to their own substance use. Louise commented, "There is a lot of drug use [at transition houses]. People that are in recovery, it's very hard for them to stay in recovery and to be around people like that." Women also identified that they risked their sobriety due to the location of services within neighbourhoods where drug and alcohol use was rampant. Erin explained, "There isn't anywhere for people on pain medication to access treatment or recovery except . . . the only options are in the Downtown Eastside around all the drugs and stuff. It isn't impossible to stay sober, but it's really really hard."

Women, particularly those living in Vancouver's Downtown Eastside, generally spoke negatively about prescription medications, most often methadone, disclosing past experiences of being under medicated, over

medicated, medication ineffectiveness or intolerable side effects. Some women stated that medications prescribed by their psychiatrist or family physician enabled their addiction, as illustrated by Nell in stating, "My doctor is my drug dealer. I tell her that I have someone else that deals with my health. You're just my drug dealer." Comparatively, other women identified that prescription medications caused their addictions, as suggested by Crystal's comment, "They put me on methadone without me doing heroin; turned me into a junkie." For women who had previous experiences of addiction, some disclosed that prescribing practices compromised their sobriety. Angel recounted, "I can't believe [my doctor] wanted to write me a prescription for morphine. I said 'quite frankly I'm surprised you offered morphine because you know I'm an ex-morphine addict' or user I should say, because I'm still addicted, up here [pointing to her head]."

Some women spoke of the power that prescribers, including physicians and psychiatrist, held by controlling their medication regimes and how they could use this power to punish women for bad behaviour. Maria explained, "When I missed my appointment for the first time in 3 years, he [her physician] knocked me down from 80mg to 40mg [of methadone]". Women identified that when prescriptions did not match their needs, they engaged in self-medication to manage their pain or addiction, as illustrated by Sandra in stating, "I'll self-medicate with drugs. I'll do it myself. I'll do what they're [physicians] supposed to." Jules disclosed that she engaged in sex trade work for heroin because she was unable to obtain a prescription for pain medication from her physician. She

stated, "It was ridiculous, I couldn't walk and I had to use heroin. So if I have to do some sex trade work to pay for heroin to ease my pain, that's insane."

Women generally suggested that physicians under prescribed medications for those who had past or current experiences of addiction due to fears of causing or enabling their addiction. Yet, women suggested that under prescribing merely resulted in them self-medicating with street drugs as illustrated by Jill in stating,

> Once they know you're an addict they think everything is going to feed your addiction. So they say, "you can't have this for pain, you can't have that for pain". So you end up self-medicating. And we shouldn't have to self-medicate.

Too often, women suggested that addictions and mental health service provider neither listened to nor valued their opinions. Instead, women generally suggested that these service providers overly medicalized their problems, often resulting in the provision of prescriptions opposed to receiving services. Women suggested that this lack of collaboration between service providers and service consumers resulted in prescriptions and treatment plans being unreflective of their reality, which reduced women's ability to comply.

3.1.3 Mistreatment from service providers created a barrier to help-seeking

Many women disclosed that their experiences with services were adverse due to mistreatment from individual service providers- including being disrespected, judged, labelled, discouraged, dismissed, blamed and disbelieved.

This mistreatment was identified as happening across all sectors, but most commonly identified to be occurring by transition house workers and health care professionals in emergency room departments. Women believed that their mistreatment stemmed from service providers own stigmatization of women experiencing abuse, substance use and mental health issues, as illustrated by Sandra in stating,

> Emergency . . . They don't like addicts. They don't like people with mental health issues. Medical people aren't recognizing addictions or mental health. They see it as a self-made problem. And you get treated like that. You deserve it . . . And it feels that way.

Women identified that they were treated especially poorly by service providers when they disclosed that they used substances. PJ, a "recovering addict" explained, "When I dealt with health care professionals, especially when I talked about addiction, my words weren't of value. My voice didn't mean anything." Once women felt mistreated by service providers, they struggled with feeling responsible for their own suffering and undeserving of help. Sandra illustrated this in stating, "I don't know how many times I've been raped . . . And a lot of it, you feel like you deserve it and they make you feel that way too. A lot of doctors and stuff. You don't want to go for help."

3.1.4 Inattention to women's experiences of abuse made services unreflective of women's needs

Many women identified that addictions and mental health service providers were uninformed about abuse and associated trauma. Because

service providers were uninformed about these issues, they frequently disbelieved women when they disclosed their stories. This resulted in women having to prove their suffering to receive the support they needed, as illustrated by June in stating:

> [A] doctor told me that he doesn't want me on T3s and won't write me a prescription. He's not even my doctor. So I started yelling at him. I pulled up my pants and I showed him the scars and I shouldn't be having to defend my pain. I shouldn't have to beg for pain medication

Although women commonly identified abuse as being central to their experiences of substance use and mental health issues, many stated that mental health and addictions service providers diminished their experiences of abuse, treating it as secondary to addictions counselling, mental health treatment or life skills development. A few women even reported that their experiences of abuse were diminished within services that had primary mandates of supporting abused women, as was illustrated by Lynn, a woman previously involved in prostitution, in stating, "[The program's mandate] is sexually exploited female youth . . . but there was nothing about being sexually exploited within their program."

Women also described how addictions and mental health service providers, including counsellors, psychologist and psychiatrists, commonly asked them to push aside their experiences of abuse and trauma to work in the present. As stated by Cindy, a woman who experienced abuse as a child, "I find with a lot of drug and alcohol counsellors, their saying, 'don't think about the past, let's go

for the future'. It doesn't work that way". As a result, women often suggested that they, "never dealt with the abuse issue."

Since service providers were often uninformed about abuse, women recognized that their abusers could manipulate service providers so that they could be included in their partners care. Women most commonly stated that mental health service providers and family physicians allowed partners to be present during appointment times. Women across groups repeatedly stated that an abusive partner's inclusion in their care placed their safety at risk. Jordan explained that at a doctor's appointment, "He [the abuser] sat right beside me. I couldn't say anything. And if I did, I would have gotten beats when I got home." Riley, a woman whose partner often confined her to a trailer, similarly stated, "How can anybody ever feel free to come clean with a counsellor when you have the abusive partner there beside you and you have to go home with him? And yet, I agreed to it because he was standing there".

Another result of services being uninformed about abuse and associated trauma was that some women's encounters with services were potentially traumatizing. Because power was often not shared between service providers and service consumers, some women identified that their interactions with services mirrored their experiences of being dominated and controlled by their abusive partner. The most overt potentially traumatizing experience disclosed was by Pam, a 60-year-old woman, who explained:

> I was a shock when I first came [to the transition house] . . . I was locked in for a weekend . . . What happens is when you go into a safe house is

> you're locked in, your doors are bolted and your windows and you can't make any phone calls. Nothing. That was driving me even crazier. Literally, I couldn't breathe . . . It was a horrible, horrible weekend. I thought, "that's it. I'm a goner".

Women also identified that since their experiences of abuse most commonly occurred at the hands of men, contact with male service providers was not preferable, and in a few cases, potentially traumatizing.

3.1.5 Child apprehension directly contributed to mother's use of substances

Mothers consistently revealed that fears of losing custody of their children created a substantial barrier to accessing services. Across many focus groups, mothers discussed their negative experiences with the Ministry of Children & Family Development's (MCFD) Child Protection Services (CPS), which was most often related to child apprehension. Jane explained, "Asking for help- as soon as you ask for help- boom! They take your kids." Unfortunately, it was not clear how women came into contact with CPS when engaged with anti-violence, addictions and mental health services. However, women most commonly explained that their children were removed from their care because of exposure to violence within the home, women's substance use or lack of suitable housing.

Many mothers disclosed the immense suffering they endured surrounding their child's apprehension. In response to having their children removed from their care, mothers explained that their substance use was adversely affected, which seemingly occurred in two different ways. The first way that apprehension

adversely impacted mother's substance use was that it negatively affected mother's treatment outcomes. Many mothers explained that their children provided a source of strength to overcome adversity in their lives. Therefore, once this source of strength was removed, mothers identified that their motivation for positive change was lost. Sheri, a mother of two, explained, "I tried going to the treatment centre, but that didn't work because of the social workers' involvement. They gave the kids back to him. I thought it wasn't necessary that I finish so that sabotaged me finishing the treatment. After that I started using alcohol again."

The second and more frequently cited way that apprehension adversely affected mother's substance use was that it resulted in mother's using substances to cope with the pain of the absence of their children. Liz, a mother of two, illustrated this in stating:

> I was doing pretty good until the Ministry of Children Development stepped in . . . She whipped my kids out and put them in foster care . . . And that made me ten times worse than I would have been had I had my kids . . . But she literally took them. Wouldn't let them talk to me . . . That is the week I fell harder. That's the week I went nuts on drugs. And that's the week I started selling drugs. And that's the week I was literally punching windows . . . I'm not a violent person. But because they did that to me without giving me a chance, they made me worse than I was.

Similarly, Cindy recalled that when her son was three months old, "The ministry came in and took my son away . . . In those days, I started shooting heroin again.

I was never given the chance to explain." Liz compared the impact of losing her children to that of the impact of being raped and tortured.

> My life was just starting to get good. And then they ripped my kids away. It literally threw me down the darkest hole I've ever been in, even after being raped and tortured. This was almost worse . . . I went straight to the crack dealer's house and he handed me the pipe and a big pile of dope and I was gone for a week. I never slept for a week. I was a mess.

Women suggested that CPS should avoid removing children and instead provide "more support and understanding" to women who have experiences of abuse, substance use and mental health issues.

4: DISCUSSION

This paper identified five different ways in which women are being harmed by practices and policies embedded within BC's anti-violence, addictions and mental health services. Specifically, exclusion from services undermined women's ability to escape high-risk situations; contact with services triggered women's substance use; mistreatment from service providers created a barrier to help-seeking; inattention to women's experiences of abuse made services unreflective of women's needs; and child apprehension directly contributed to mother's use of substances.

As evident from these findings, many of the harms of services compounded women's experiences of abuse, substance use and mental health issues. Therefore, practices and policies, which may not be harmful to another population group, were indeed harmful to these women because of their past or current experiences with these three issues. One example of this was the inclusion of a woman's partner in her care. While this inclusion may be beneficial for a woman in a safe, healthy and supportive relationship, when this same practice is applied to a woman living in the context of an abusive relationship, it can compound the harm of abuse by compromising safety.

The women in this study validated much of the extensive literature documenting the challenges facing the anti-violence, addictions and mental health sectors in meaningfully responding to the "other" issues in women's lives.

Generally, women suggested that anti-violence services, specifically transition houses, used their substance use and mental health issues as a means to exclude them from services. In contrast, women explained that although addictions and mental health services did not exclude women impacted by abuse, they offered limited support to women to address this important aspect of their lives.

Perhaps what was unexpected was that some women identified that services were causing harm to issues that fell inside the sectors' designated mandate. For example, some women identified that despite transition houses' primary mandate of enhancing safety, these services, at times, reduced women's safety by forcing them to exit services after designated periods of time, with limited alternative but to return to an abusive partner.

This study also revealed that services are particularly harmful for certain groups of women, namely mothers, especially those who were simultaneously experiencing poverty. The adverse effect of child apprehension on mothers, specifically regarding their substance use, was noteworthy. This finding contributes to previously conducted research examining the impact of child apprehension on mothers, which has revealed the re-victimization abused women experience when CPS remove their children from their care (Bennett & Sandrehashemi, 2008), adversely affecting their self-esteem, loss of child tax credits, reduction of social assistance and ineligibility for housing (Callahan, 1993). Since a child's well-being is intimately connected to their mother's well-being, as is outlined by the MCFD's, *Best Practice Approaches: Child Protection*

and Violence against Women (2004), this finding affords serious consideration by MCFD.

Despite the value of these findings in contributing to our understanding of service harms, they also indicate the complexity of providing recommendations to remediate the problem. One example of this complexity was contradicting perspectives on policies surrounding substance use within transition houses. Many women spoke of the harms of abstinence-only transition houses, in that they exclude women who cannot maintain sobriety. Conversely, other women spoke of the harm of transition houses that supported substance-using women as they felt exposure to others substance use was triggering to their own substance use. Clearly, the practice and policy decisions facing these sectors are challenging, as what may be beneficial for one woman may actually be harmful for another.

Another example of this complexity was illustrated in regards to prescription medications. Some women suggested that physicians either enabled or caused their addiction by over prescribing. On the other hand, other women spoke of self-medicating with street drugs when the amount prescribed was inadequate. Such harms disclosed by women maybe a result of the tensions that exist between variations to models of care, such as the medical model, employed by the addictions and mental health service sectors.

4.1 Recommendations

The following three recommendations are provided to support the anti-violence, addictions and mental health sectors to eliminate service harms.

4.1.1 Women-centred care

The recommendation for women-centred care is provided to ensure that services support each woman to guide and direct her own care based on the needs she identifies. If this recommendation is applied, the diverse, varied and, at times, contradicting needs and perspectives of women will be reflected within service responses. Specifically, this recommendation will remediate the harms of services by ensuring that women are listened to and valued as experts of their needs; that relationships between service providers and women are collaborative rather than hierarchical; and that women are supported in the diverse roles that they occupy, including being mothers. Within this study, it was particularly evident that addictions and mental health services most urgently need to integrate women-centred care.

Women-centred care emerged from the women's movement as feminists advocated for an equitable health care system that was responsive to women's unique needs (Barnett, White & Horne, 2002; Doyal, 1998). The cornerstones of women-centred care include a focus on women, women's involvement and participation, empowerment, respect, and safety (Barnett et al., 2002). Furthermore, women-centred care recognizes the complexities of women's lives, is inclusive of diversity, responds to women's forms of communication, is integrated, and provides information and education (Barnett et al., 2002). What

differentiates women-centred care from patient-centred care is that it contextualizes care to the social, political and economic inequality of women (Morrow, 2003). Women-centred care aims to value women as individuals, as well as in the diverse roles they fulfil, such as being mothers and partners (Morrow, 2003).

Within the province, the Fir Square Combined Care Unit at BC Women's Hospital provides one promising example of women-centred care in practice. By working within a women-centred care model, this unit provides antepartum and postpartum care to substance using mothers and substance-exposed newborns on the same unit. The goals of Fir Square are to reduce mother's substance use and other risky behaviours, support mother's readiness for treatment, improve substance using mother's access to services, improve perinatal outcomes and increase the percentage of mothers able to retain custody of their babies (BC Women's Hospital and Health Centre, 2010).

4.1.2 Trauma-informed and trauma-specific services

The recommendation for trauma-informed and trauma-specific services is provided to ensure that the anti-violence, addictions and mental health sectors respond in a positive way to women who have experiences of abuse and associated trauma. If this recommendation is applied, it will ensure that abused women can participate in and benefit from services in a way that is safe, affirming and empowering. Specifically, this recommendation would remediate the harms of services by ensuring that safety-compromising practices are eliminated; that women's experiences of abuse are recognized, validated and supported; and that

service providers build positive relationships with women, which emphasize women's "adaptations over symptoms" and "resilience over pathology" (Elliot et al., 2005, p. 467). Within this study, the need for all three service sectors to integrate trauma-informed and trauma-specific services was evident.

Although not designed specifically to address trauma, trauma-informed care considers all aspects of programming through an understanding of trauma (Fallot & Harris, 2001; Markoff, Glover Reed et al., 2005). In other words, this approach to care applies a "trauma lens" to practice and policy decisions (Fallot & Harris, 2001; Guarino, Soares, Konnath, Clervil, Bassuk, 2009; Markoff , Glover Reed et al., 2005). Given the pervasiveness of abuse, as well as the challenges in differentiating abused women from non-abused women, trauma-informed services treated all women with "universal precautions" (Markoff, Glover Reed et al., 2005, p. 532). Since the essence of traumatic experiences are a violation of a person's safety, promoting safety and security within services is a primary principle of trauma-informed care (Elliot et al., 2005; Hodas, 2006; Markoff, Glover Reed et al., 2005). Another fundamental principle is a strengths-based empowerment model, which, for example, understands that symptoms, such as substance use, may originate from a survivor's means of coping and adapting to trauma (Elliot et al., 2005; Hodas, 2006; Markoff, Glover Reed et al., 2005). Other guiding principles include sharing power, supporting trauma-survivor involvement, integrating care, and promoting healing and recovery (Elliot et al., 2005; Guarino et al., 2009; Hodas, 2006; Markoff, Glover Reed et al.,

2005). Conversely, trauma-specific services are those designed for the primary task of addressing trauma and facilitating recovery (Fallot & Harris, 2001).

Within BC, the Woman Abuse Response Program's *Safety and Health Enhancement (SHE) Framework* offers promise for integrating trauma-informed care throughout health care systems. This conceptual framework examines the overall safety of the health care system for women impacted by abuse and advocates for a women-centred, trauma-informed approach to care. The *SHE toolkit* guides health care providers, policymakers and planners to assess the potential risks and harms of health care practices and policies. The toolkit supports users to incorporate evidence-based practices for promoting women's health and safety (Cory & DeChief, 2007).

4.1.3 Integration across anti-violence, addictions and mental health sectors

The recommendation for integration is provided to ensure that practices and policies across sectors reflect the strong association between woman abuse, substance use and mental health issues. If applied, this recommendation would ensure that when women encounter services, all aspects of lives are considered, supported and respected. Specifically, this recommendation would remediate the harms of services by supporting women to address their experiences of abuse, substance use and mental health issues simultaneously rather than sequentially. As well, integration would ensure that services include women rather than exclude them based on having multiple issues.

While integration has previously been proposed as a strategy for addressing populations and individuals with multiple needs, it is notable that integration can occur at two levels: the service level and the system level. Service integration has been defined as the coordination of different service sectors to improve service delivery for an individual client with multiple needs, without fundamentally changing the relationships between sectors (Cocozza et al., 2005). Conversely, system integration has been defined as the coordination of different service sectors to improve service delivery as a whole for a defined population that has multiple needs (Cocozza et al., 2005). It is noteworthy that within the Women Co-occurring Disorder and Violence study, service level integration was achieve through offering integrated counselling services (Cocozza et al., 2005) and system level integration was achieved through the implementation of the "relational systems change" model (Markoff, Finkelstein et al., 2005).

Sheway, a pregnancy outreach program located in Vancouver's Downtown Eastside, provides an example of a promising program that has successful integrated services on the system level. Developed out of a partnership established between Vancouver Coastal Health, Vancouver Native Health, the Ministry of Children and Family Development and the YWCA, Sheway provides a one-stop shop of specialized services for mothers and expectant mothers who use substances (Sheway, 2006).

4.2 Limitations

Several limitations of this study require consideration. Researcher bias may have been present, as the Woman Abuse Response Program and this author were involved in organizing, facilitating, transcribing and analyzing each focus group and interview. Considering that the Woman Abuse Response Program, a feminist advocacy organization working in the area of woman abuse, was the lead agency of the initiative, participants may have biased their responses to emphasize their experiences of abuse over their substance use and mental health issues. Since these data were entirely self-reported, the accuracy of reporting must be considered, especially given the sensitive nature of the data being collected.

Selection bias also may have been present within this study. Anti-violence services were responsible for the recruitment of the study's participants to ensure that women were adequately supported. This meant that recruitment was not conducted through mental health or addictions, which may have limited representation of women engaged with these services. As well, the study's inclusion criteria of participants having had to receive past or current support for their experiences of abuse would have excluded women who were not in contact with services. Since demographic data were not collected from women, the participant's diversity, in regards to age, race, ethnicity, class, sexual orientation and other forms of social difference were not fully understood. Service experiences specifically for Aboriginal women were not addressed and there exists a need for research on cultural safety for this population group.

At times during the focus groups, women broadly discussed the harms of "services", making it not possible to differentiate between which services- anti-violence or addictions or mental health- were causing harm. As well, since women within these focus groups were not directly asked to discuss services harms, it cannot be assumed that these findings provide a full picture of the problem.

5: CONCLUSION

This paper provides a preliminary examination of a complex issue worthy of further research. These findings indicate that women who have experiences of abuse, substance use and mental health issues are being harmed by practices and policies embedded within BC's anti-violence, addictions and mental health services. If service providers, planners and policymakers intend to maximize the benefits of services to enhance these women's health and safety, it is imperative that services reflect the experiences and needs of the population they serve.

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APPENDIX

Interview Guide

Preamble (after informed consent is granted): Thank you for agreeing to speak with us about the links between your experiences of abuse, substance use and mental health issues and how it has affected your ability or desire to access services.

We are also talking to other women from around the province who have experienced these issues to learn about the impacts they have had on women's lives, and accessing services. We want to further our understanding of how community and health services can better address these issues. The purpose of this study is to help community service workers and health-care providers understand how they can help to create more effective programs and policies to address violence against women, substance use and mental health issues together.

We understand that women's experiences of violence are closely linked to addiction and mental health and that it is difficult to talk about experiences when accessing services without talking about the impact of the violence in your life. Today we would like to focus on your experiences with services and service providers. Support will be available after the focus group if you want or need to talk to someone about the violence in your life or anything else that comes up for you.

The questions we are going to ask you to think about today do not have right or wrong answers. You may want to take a few minutes to think about your responses to questions and that may create some silence. That's OK. We're comfortable with that and we hope you will be too. If you'd like, you can always choose not to answer a question, too. If you're not sure what we mean by a question, please feel free to ask us to clarify.

The discussion will reveal information that is of a sensitive and private nature. We hope that each of you will feel comfortable to share your thoughts with the group and that each of you has the opportunity to do so. To encourage this we ask that everyone is respectful and refrains from interrupting when someone else is speaking. We ask that you respect the privacy of all the women present and ensure that everything that is shared here today does not get shared with anyone outside this group.

We will begin by asking each of you to introduce yourselves. However, in order to protect your privacy we ask that each of you choose a pseudonym and introduce yourself to the group using this pseudonym. Please continue to use this pseudonym throughout the duration of the focus group.

Does anyone have any questions before we begin?

Opening Statement:

Tell us in your own words about the links between abuse and violence, drug or alcohol use, and mental health issues in your life.

Probing questions:

a) Can you describe the links in more detail?

- When did you start seeking support for each issue (abuse/problematic substance use/mental health concern)
- Which issues did you seek support for first?
- Did experiencing one issue make it more likely that you experienced another?
- Do you think that one issue is a direct result of another?

b) Did you ever try to get services for one or more of these issues?

- What happened when you went to get services?
- Did you face any barriers accessing services?
- How would you describe your needs at this time?
- How did your relationship affect your ability or willingness to seek services for your substance use or mental health issues?
- Can you describe a situation where you chose not to seek health-care when you thought you needed it?
- What did service providers do that was really good or helpful?

c) Given your experiences, what kinds of improvements could community and health services make to better support women facing these intersecting issues?

- Which services are in the best position to help women?
- What needs to be done to help service providers understand the issues better?
- What needs to be done to help service providers develop better skills to help and support women?
- What would relevant and effective service provision look like to you?

d) Is there anything else you want to tell us about your experiences?

e) Thank you for taking the time to talk with us about your experiences. If there were any questions that brought back some unpleasant memories, we want to let you know that if you need or want to debrief with someone, _____ (someone at their respective service organization) is available to talk with you.