

Report on Violence Against Women, Mental Health and Substance Use

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A. Introduction

This report is the summary of a review conducted for the Canadian Women’s Foundation to enhance the grant making, analyze emerging trends, and understand the current philanthropic environment of services for women who have experienced violence and who have mental health and substance use concerns. The review involved consultations with women with lived experience, service providers and representatives from various ministries across Canada through email and via phone. A total of 10 people were interviewed via phone, another 20 responded to questions via email and many more contacted us with direction on who to contact and other useful information for the review. In addition to these interviews, we reviewed literature in Canada and Internationally for current knowledge around and promising practices for supporting women impacted by these intersecting issues. Finally, we have drawn on research findings from BC Society of Transition Houses’ Reducing Barriers project and our partners, the Woman Abuse Response program at BC Women’s Hospital & Health Centre’s Building Bridges project (see Appendix for description).

B. Overview

Intersections of Violence Against Women, Mental Health and Substance Use

It is estimated that in Canada approximately 1 in 3 women have experienced violence at some point in their adult lives and that 1 in 10 women are presently experiencing violence.¹ Violence against women is the most frequent cause of injury to women in this Country.² Women impacted by violence in their relationships experience various negative health effects and are more likely to rate their overall health as poor compared to women who have not experienced violence.³ The estimated annual cost to the Canadian health care system for medically treating women who have experienced violence ranges from \$408 million to \$1.5 billion.⁴

Experiences with violence can have various impacts on women’s physical and psychological health, including their levels of mental health and substance use. Researchⁱ affirms that women's health is profoundly impacted by violence, mental health and substance use and the co-occurrence of these three conditions can adversely impact the outcome of each.⁵ In order to understand the nature of the association between violence against women, substance use and mental health concerns, researchers have attempted to establish a temporal order of these three issues.

ⁱ While the research is growing in this area, there is a paucity of Canadian research on the links between woman abuse, substance use and mental wellness. Canadian research was included in this report as much as possible, but had to be supplemented with research primarily from the United States and the United Kingdom, where the majority of research has been conducted.

Compelling research has been conducted demonstrating that women's experiences of violence precede their substance use and/or mental health issues.⁶ In fact, some researchers have argued that such consistent correlations between violence against women and mental health and substance use issues suggest a causal relationship.⁷ For example, approximately two-thirds of women accessing anti-violence services report that they began their problematic substance use following experiences of violence in their relationships.⁸ At the same time, there is evidence that substance use and/or mental health concerns can create a vulnerability to violence and that the pre-existence of these conditions may exacerbate the effects of abuse.⁹ The association between these three issues is, therefore, both complex and multidirectional.¹⁰

There is compelling research demonstrating that women's experiences of violence precede their substance use and/or mental health issues.

The association between violence against women, substance use and mental health has been studied using various research methods and approaches, all showing that women who have experienced violence have significantly higher rates of substance use and mental health concerns compared to women who have not. One study found that 50% of all women surveyed who had experienced violence had a clinical mental health diagnosis compared to only 20% of women who had not experienced violence.¹¹ A study by Dutton et al. found the risk of developing depression, posttraumatic stress disorder (PTSD), substance use issues or becoming suicidal was 3 to 5 times higher for women who have experienced violence in their relationships compared to women who had not.¹² Logan, Walker, Cole, & Leukefeld also found that women impacted by violence in relationships had elevated risks of developing depression (26.3% higher), PTSD (53.4% higher), and alcohol dependencies (12.2% higher).¹³

Women who have experienced violence have significantly higher rates of substance use and mental health concerns compared to women who have not.

It is rare that women who have experienced violence only experience impacts on either their mental health or on their substance use alone – these impacts are often co-occurring. Studies across anti-violence, mental health and substance use services have shown that women entering these settings have overlapping experiences of violence, mental health and substance use concerns. An Ontario-based study revealed that regardless of which sector- anti-violence, mental health or substance use - women were in contact with, each had a similar number of experiences of abuse, substance use and mental health issues. 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 choose to engage with.¹⁴

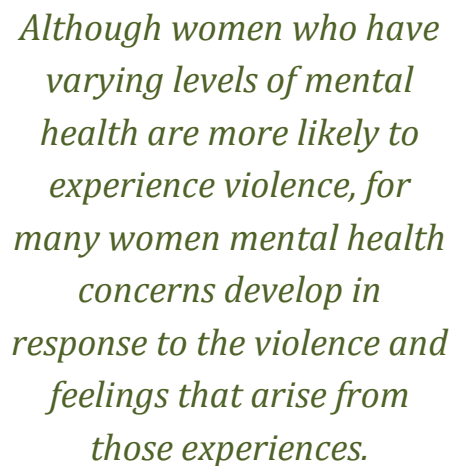
More specifically, it is estimated that close to 67% of women with substance use issues have a concurrent mental health problem such as PTSD, anxiety, and depression.¹⁵ Within community mental health services, it has been documented that almost half of women have a co-occurring

substance use disorder.¹⁶ In transition houses, it has been documented that over half of women suffer from major depression¹⁷ and over 33% suffer from PTSD.¹⁸ The prevalence of substance use disorders among women in these houses has been estimated to range from 33% to 86%.¹⁹ Clearly these issues are deeply connected, but we explore the links between violence and mental health and violence and substance use separately below.

Violence and Mental Health

Experiences with violence can have significant impacts on women’s mental health. Systematic reviews examining the link between violence against women and depression have found significantly higher rates for women who had experienced violence in their lives compared to general populations of women. For example, Cascardi, O’Leary & Schlee reviewed 14 studies and found prevalence rates of depression to be between 38-83%, while Golding found an average prevalence rate of 47.6% for women impacted by violence.²⁰ In Canada, the lifetime prevalence of depression for women is estimated to be 12.2%.²¹ Among mental health inpatient populations, one study estimated that 83% of women had been exposed to severe physical or sexual violence as a child or adult.²²

Abusers may use a woman’s levels of mental health against her, by keeping medications from her or over medicate her; taking advantage of changes in her symptoms or feelings (i.e. encouraging suicidal thoughts); claiming that she is an unfit mother, and/ or minimizing her credibility.²³ Although women who have varying levels of mental health are more likely to experience violence, for many women mental health concerns develop in response to the violence and feelings that arise from those experiences.²⁴ As Morrow and Chappell argue, “[f]or many women social conditions of inequity, in particular experiences of violence, precipitated their entry into the mental health system.”²⁵ As a result, many researchers and service providers believe that it would be rare for women to experience violence without having some kind of mental health consequence. In fact, The World Health Organization has declared violence against women to be the leading cause of depression for women.²⁶ Therefore, researchers and women themselves believe that many mental health concerns are natural responses to the violence women experience and should be responded to as such.²⁷



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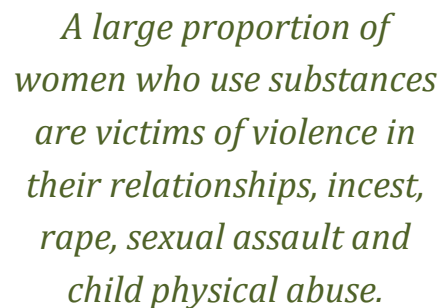
Despite the evidence for these kinds of frameworks, the connections between violence and mental health are often lost. Anecdotal accounts and research show a trend in which health and mental health professionals have been increasingly labelling women who have experienced

violence with mood disorder diagnoses such as depression and borderline personality disorder with little or no consideration for the social context that may be contributing to her concerns.²⁸ These mental health labels can be stigmatizing and create barriers to services. For example, women with BPD are sometimes seen as ‘difficult to work with’ and are referred on or even refused access by service providers in various sectors.²⁹ Some specialists prefer that, if a diagnosis is to be made, Post-Traumatic Stress Responses (PTSR) be used so that the stressors underlying any mental health symptoms are acknowledged.³⁰ Whatever diagnoses a woman is given, anti-violence advocates believe that it is up to the woman to decide whether or not a mental health label makes sense or applies to her experiences.

Finally, women are prescribed medications by physicians for mental health concerns, including depression and anxiety, more than any other medication.³¹ These medications are often prescribed without consideration of the underlying problems may actually contribute to women’s experiences of violence. For example, 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. Yet, many anti-violence and specifically Transitional Housing programs require women to take medication, undergo a thorough assessment and to have contact with mental health providers if women disclose any mental health concerns.³²

Violence and Substance Use

Research shows that a large proportion of women who use substances are victims of violence in their relationships, incest, rape, sexual assault and child physical abuse.³³ For example, the United Nations has recognized that experiences of relationship violence have lead to increased alcohol and drug dependency in women.³⁴ Women impacted by violence are more likely to smoke cigarettes, use alcohol heavily, misuse prescription drugs, and use illegal drugs.³⁵ Alcohol dependency has been found to be up to 15 times higher for women impacted by violence than in the general public.³⁶ Additionally, victims of violence are more likely to use multiple types of substances and to use higher levels of substances than those who have not experienced violence.³⁷



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Within substance use services in Canada and the US, researchers have illustrated the links between violence, mental health and substance use. Within substance use treatment, approximately 40% of women have a co-occurring major mental health disorder, up to 67% have a history of abuse, and almost 50% are in a currently abusive relationship.³⁸ In another systematic review, Najavits, Weiss & Shaw found that 36-51% of women in community samples reported a lifetime history of physical and sexual violence compared to 55-99% of women with substance use issues.³⁹ In a BC study of 512 young Aboriginal people who smoke or inject drugs,

a large majority (68%) of the 262 participating girls and young women had experienced early childhood sexual abuse, with a mean age of 7 years.⁴⁰ And at Aurora Centre, a women's addictions treatment centre in Vancouver, BC, 63% and 41% of the 248 women who responded had experienced physical and sexual violence as adults, respectively. In addition, 48% and 46% of the women had experienced physical and sexual violence as children, respectively. Fifty-two percent of the women were also taking antidepressants at the time of treatment and 33% reported symptoms of disordered eating.⁴¹

In another study of substance using women from nine treatment centres across Ontario, 85.7% of the 98 women in the sample had been victimized. Women reported being a victim of adult physical violence (56.1%), childhood sexual violence (56.3%), childhood physical violence (56.1%) and adult sexual violence (45.4%).⁴² Despite this evidence, many services fail to respond to these connections when serving women.

Many women who use substances and who access anti-violence services use substances to cope with the violence, the resulting effects on their physical and mental health or other stressors in their lives.

Women use substances for a variety of reasons, but many women who use substances and who access anti-violence services report using substances to cope with the violence, the resulting effects on their physical and mental health or other stressors in their lives (poverty, lack of safe, affordable housing, etc.).⁴³ For example, after surveying women in BC Transitional Houses, researchers with the BC Centre of Excellence for Women's Health (BCCCEWH) found that the number one reason women gave for using alcohol was to cope.⁴⁴ The researchers also found that supporting women around their experiences of violence and other stressors can reduce

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stress and, in turn, help reduce levels of substance use. In the BCCCEWH research, women who accessed support through a Transitional Housing program reported a decrease in their substance use and were less likely to identify their substance use as a concern, even when they received little support around the substance use specifically.

In addition to using substances to cope, findings from "Building Bridges" consultations, part of a province-wide study conducted by the Woman Abuse Response Program at BC Women's Hospital & Health Centre, indicate that abusive partners play a significant role in women's substance use.⁴⁵ Women in the Building Bridges, Reducing Barriers and other consultations report being coerced or forced to use substances by their partner as a control mechanism.⁴⁶ Abusers often introduce women to alcohol or drugs, thereby increasing her dependence and his control. Many women describe how their substance use began or escalated as a response to experiences of abuse; how substance use created temporary safety by placating their partners; and that efforts to stop using substances precipitated the abusers' use of increased violence or control tactics.⁴⁷

What about men?

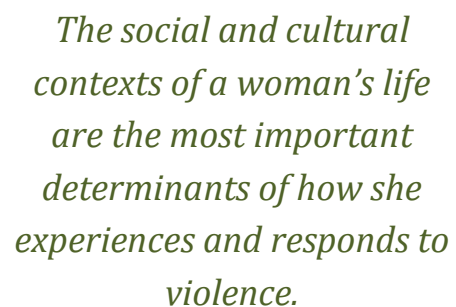
These strong associations between violence, substance use and mental health concerns are found to be much higher for women than men. MacMillan et al. have found that women with a history of physical violence have “significantly higher lifetime rates of major depression and illicit drug abuse/ dependence than did women with no history”.⁴⁸ This association was not found in men. The Ontario Canadian Mental Health Association has also found that there is a significant correlation between a history of sexual violence and the lifetime number of suicide attempts, and this correlation is twice as strong for women as for men.⁴⁹

Societal Context: Contributing Factors & Gaps in Service

Lee, Thompson & Mechanic argue that the social and cultural contexts of a woman’s life are the most important determinants of how she experiences and responds to violence.⁵⁰ For example, barriers resulting from a woman’s low socioeconomic status, immigration status, geographic location, and discrimination due to gender, age, race, sexual orientation, ethnicity and her levels of mental health and substance use can all compound the experiences of violence and reduce a woman’s ability to access support. It is, therefore, important to understand the ways that these different inequalities intersect in some women’s lives to compound their experiences and/or risk of violence, substance use and/or mental health concerns.⁵¹

Women impacted by violence, mental health concerns and/or substance use often face high levels of discrimination and judgment in society and in the services they attempt to access.⁵² The unemployment rates for people with mental health concerns are between 70% and 90% in Canada; this contributes to high rates of women with mental health concerns living in poverty.⁵³ Women who use substances are also at high risk of poverty and have traditionally been viewed as deviant and undesirable, which influences the way they are treated by service providers, police, and society in general.⁵⁴ Women consulted in BC Society of Transition Houses’ Reducing Barriers project and informants for this report spoke to gaps in provincial government services designed to alleviate these challenges.

Interviewees noted the severe shortage of affordable and safe housing, low and underpaid employment, unhelpful incomes assistance policies, a lack of affordable child care and overzealous child welfare agencies. For example, respondents from two different provinces spoke of ‘cumulative care’ policies within child welfare ministries. These types of policies mean that women who place their children in government care for safety concerns or to receive support around their mental health or substance use concerns will have their children apprehended permanently if the youth are in care for a certain number of



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cumulative (not consecutive) days. These conditions make it difficult for women to seek support around or leave abusive relationships or to support themselves and/or their children on their own.

Those we consulted said that government bodies fail to act in cooperation, further compounding harms to women. For example, more than one person consulted for this review spoke of situations where women were told that they could not gain access to their children who had been apprehended unless they obtained their own safe housing, away from the abuser. Yet, without access to their children, women who live in poverty are unable to receive the level of income support needed to afford even subsidized housing. This lack of coordination and the failure to take into consideration women's unique contexts in public services can contribute to a woman's feelings of dis-empowerment and frustration and thereby further impact her levels of mental health and/or substance use.

Barriers women face at the systems-level and in services, include:⁵⁵

- ◆ *difficulty accessing social services and child care;*
- ◆ *need for support and education around parenting;*
- ◆ *lack of long term counselling and support groups for experiences of violence/ abuse;*
- ◆ *lack of long term and safe housing;*
- ◆ *lack of vocational and legal assistance, etc*

Aside from challenges that make it difficult for women to leave violent relationships, women who experience violence and who have varying levels of mental health and/or substance use face many barriers to accessing treatment and support for any of the three concerns. Many services, including health care and anti-violence services, refuse to serve women with addictions or mental health diagnoses, limiting access for this vulnerable population and minimizing the role that violence plays in their lives.⁵⁶

While the strong association between violence against women, mental health and substance use concerns has been established within the literature, developing practices and policies that adequately reflect these links has challenged the anti-violence, mental health and substance use sectors.⁵⁷

Findings from the Building Bridges and Reducing Barriers projects in BC reveal that few agencies and practitioners in the province are equipped to provide the range of services needed by women impacted by violence who also experience mental health and/or substance use concerns. This situation does not seem to be unique to BC though, as informants across Canada identified the lack of holistic, integrated support where women can speak to their experiences with violence and the resulting impact on their mental health and substance use as one of the largest gaps in services at the time. The lack of recognition of the connections between experiences of violence, mental health and substance use and, consequently, programming that can support women with these intersecting concerns means that the women who need the most support are often the most marginalized from services.⁵⁸

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Integration across the anti-violence, mental health and substance use sectors has not occurred for numerous reasons. One predominant reason for the separation of services that many informants for this report spoke about is the philosophical differences (and sometime the perceived philosophical differences) between sectors. Anti-violence services, which grew out of the women's movement, have historically understood violence against women to be a socially constructed phenomenon that occurs within the context of women's oppression.⁵⁹ Women's empowerment and equality is often a guiding principle of service delivery.⁶⁰ In contrast, mental health and substance use services have primarily worked from a gender-neutral perspective, with the role of gender-based oppression and violence often being undervalued in understanding women's experiences.⁶¹ Furthermore, mental health and substance use services are commonly influenced by the medical model, which often emphasizes pathology over strengths, diminishes the role of violence in disease aetiology, and reduces complex social problems to treatable diagnoses.⁶²

Priorities between the three sectors 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.

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. There is often little consideration that attending to a woman's "other" issue(s) will affect success in treating her "primary issue".⁶³ Women who speak about "other" issues may have a difficult time accessing any service due to exclusionary policies across the anti-violence, mental health and substance use sectors.⁶⁴ These policies, in which a woman's use of substances may be used to turn her away from mental health or anti-violence 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.⁶⁵ Instead, these women are excluded because one or more parts of their lives do not fit into narrowly conceived mandates.⁶⁶

Many anti-violence programs have traditionally seen mental health and substance use as outside of the realm of their mandate. Workers in programs that see the connections between women's experiences of violence, mental health and substance use may be unsure of how to safely accommodate women with these intersecting concerns. For example, Morrow's survey among BC anti-violence service providers revealed that while women with mental health issues frequently requested their services, they were often only granted access if specific conditions were met. Conditions for services included that women were sober, capable of independent living and/or not a threat to other service consumers.⁶⁷ These policies make it difficult for women to gain access to services when they need them – for example in DAWN Canada's National Accessibility and Accommodation Survey, the second most common reason women were turned away from Transitional Housing programs across Canada was because of mental health concerns.⁶⁸

Aside from seeing the issues as separate, many anti-violence advocates and workers feel ill-equipped to support women with these intersecting concerns. For example, 33% of anti-violence workers in one Ontario study reported fair or poor competence levels in dealing with both substance use and mental health issues.⁶⁹ In addition, stigma and misperceptions about women with varying levels of mental health and substance use may also lead women to be turned away.⁷⁰ As a result, many women who have concerns around mental health and/or substance use are

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referred on by anti-violence service providers. Mental health and substance use services may not get at the violence that underpins the mental health and/or substance use concerns though, and may actually put women at risk of further violence.

Barriers for women in anti-violence services:⁷¹

- ◆ *lack of cooperative or collaborative services – not able to get support around more than one issues in one place*
- ◆ *judgement/stigma on the part of service providers*
- ◆ *fear that children will be apprehended because of violence, mental health and/or substance use*
- ◆ *service providers prioritizing the safety of women who are perceived as not having problems related to mental health or substance use over women who may be perceived as more difficult or, who may be seen as outside a VAW mandate*
- ◆ *unrealistic expectations requiring a woman not have used substances for a period of time before entering a Transitional Housing Program or while at anti-violence counselling*
- ◆ *requiring or referring a woman to attend AA or NA when she does not feel these are beneficial to her*
- ◆ *requiring a woman to take/monitoring a woman's prescribed medications*
- ◆ *Inflexible rules and inaccessible services and programs*

When women's experiences of violence are unacknowledged, their sufferings are made invisible and their safety needs are often undervalued.⁷² By not attending to these issues, services are placing the onus on women to address the violence and ensure their own safety, with little to no support.⁷³ Not surprisingly, many women are reluctant to engage with services that do not support them with these issues early in treatment.⁷⁴

Service providers in the mental health and substance use sectors may be reluctant to acknowledge women's experiences of violence because they believe it is a distinct issue in itself or may diminish its significance due to fear or misperceptions, concerns that addressing violence is counter-therapeutic, lack of appropriate and specialized programs, or insufficient knowledge and training.⁷⁵ For example, an Ontario-based study revealed that 40% of mental health and 37% of addictions service providers reported fair or poor competence levels in dealing with violence.⁷⁶ In addition, services are often directive and can echo characteristics of the violent relationships women are in.

Barriers for women in mental health and substance use services:⁷⁷

- ◆ *judgement/stigma on the part of the service provider*
- ◆ *a lack of understanding about violence against women which in turn leads to inappropriate services/recommendations or put women at further risk of violence*
- ◆ *services further dis-empower women/reproduce abusive relationships*
- ◆ *fears that children will be apprehended because of violence, mental wellness and substance use*
- ◆ *feelings of powerless/not included in their own health care planning*
- ◆ *experiences of increased risk of violence when cutting back on or reducing substance use or seeking support around mental health because abuser feels they have less control over the woman*

Despite the intention of the three sectors to enhance women's health and safety, research shows that services can unintentionally cause harm.⁷⁸ Policies and services that deal with violence without taking substance use or mental health concerns into account or that deal with mental health and/or substance without taking violence into account, are unlikely to be successful.⁷⁹ Women who remain in services are often forced to enter settings that focus on narrowly defined problems, rather than addressing their concerns holistically.⁸⁰ The lack of integrated services has meant that women who have experiences of violence, substance use and mental health issues have worse treatment outcomes than women with just one of these concerns.⁸¹ For example, in one study only 41% of women who were currently in a violent relationship completed treatment, compared to 77% of women who were not in a violent relationship.⁸²

These barriers to service may be compounded for women who, for example, do not speak English as a first language, may not see their culture or ethnicity represented in the programming, are criminalized or who may face other forms of discrimination and marginalization – whether outright or subtle – when accessing services. For example, women who are mothers may be hesitant to seek support for violence, mental health or substance use for fear of being reported to, and having their children apprehended by, Child Welfare systems. For women with children, contact with anti-violence, mental health or substance use services can mean losing custody of their children.⁸³ On the one hand, these mothers rely on services to attend to their own and their children's needs. On the other hand, contact with services may result in mothers coming under the scrutiny of child welfare services/Ministries, which ultimately could lead to the apprehension of their children.⁸⁴ Often, women deem the risk of apprehension as too high and therefore may not access the help they need.⁸⁵ The fear of losing their children is incredibly real for this population of women. In one study among women with co-occurring experiences of violence, mental health and substance use, almost three quarters

reported that they had lost custody of their children within the last six months.⁸⁶ These concerns are even greater for women in poverty and women of colour. For example, Aboriginal women are twenty times more likely to have their children apprehended than any other group of women.⁸⁷

Generalized Overview of Violence Against Women, Mental Health and Substance Use Service*			
Sector	Anti-Violence	Mental Health	Substance Use
Problem focus	Situated as criminal justice or social problem unless in health based setting	Situated as health problem	Situated as health problem
Primary Funders	Various Provincial Ministries – predominantly criminal justice and social services, but also housing (Counselling, sexual assault and shelter program may be under different Ministries in the same province; Shelters on reserve may funded by provincial or national Aboriginal areas of government)	Provincial health ministries	Provincial health ministries
Traditional Ideology/Philosophy	Oppression/violence towards women underlying cause of mental health and substance use (Problem society not individual)	Illness/focus on diagnosis (problem with individual) Violence often seen as a secondary issue	Unfocussed (bio-psycho-social-spiritual) Substance use may be seen as cause of experiences with violence
Solution	Support workers, peer support, counselling from anti-oppressive, women-centred framework	Clinical treatment, medication and counselling - often directive	Medical treatment, counselling and peer support – often directive

* We acknowledge that this is a simplistic description of the three very complex fields. This summary is meant to give a generalized overview and is based on a review of existing literature and the consultations done for this review.

C. Interview Themes

Informants for this review were women with lived experience, service providers and researchers from the violence against women, mental health and substance use services. In addition, representatives from various federal and provincial ministries contacted us to suggest relevant informants and to make us aware of programming and projects around these intersecting issues. The questions asked of all informants via phone and e-mail are listed in the appendix. Many of the major themes outlined below were discussed in the overview above, especially those related to service gaps. Below we summarize some of the major themes, focussing on recommendations in three areas – gaps in services, funding and public policy, and promising approaches and programs.

Service, Funding and Policy Gaps

Informant Interview Themes - Service Gaps:

- ◆ *Lack of recognition of connections between violence, mental health and substance use on behalf of funders, policy makers, services/programming mandates and individual service providers*
- ◆ *Lack of integrated services for women who have experienced violence with mental health and substance use concerns*
- ◆ *Too few services, lack of resources for existing services and resulting waitlists*
- ◆ *Predominance of a medical model vs. women-centred, anti-oppressive approaches*
- ◆ *Women who are the most marginalized – women in poverty, sex workers, homeless or at-risk of homelessness and experiencing other forms of oppression – least likely to gain access to services*
- ◆ *Lack of transportation to/from services and lack of child care/child care subsidies in programs*

Informants we consulted overwhelmingly spoke to the current lack of services that reflect the realities of women's experiences of the connections between violence, mental health and substance use. Because of the lack of recognition of these connections on behalf of funders, policy makers, services and individual service providers, women impacted by these three concerns experience tremendous challenges accessing services. When women are able to access services, they cannot count on support that is sensitive or responsive to the connections between the three concerns. When asked why these service gaps exist, a number of themes emerged; most prevalent, though, were concerns about current funding limitations and a

feeling that there is a lack of training and knowledge on violence-informed approaches to service provision for women.

Informant Interview Themes – Funding Gaps

- ◆ *Mental health and substance use programs are usually funded by different ministries than violence against women services*
- ◆ *Grants are often targeted towards one or two of the issues leaving gaps in funding for the other(s)*
- ◆ *Anti-violence services and workers are underfunded compared to other services that work with marginalized women*
- ◆ *Funding is often short-term and/or project based which makes sustainable partnerships and programming difficult*
- ◆ *Limited funding available for building relationships/collaboration across sectors and services*

We asked informants to speak about the funding sources for any promising programs or initiatives they identified. It quickly became apparent, though, that there is no one ministry, foundation or other philanthropic organization that funds programming for these intersecting concerns. In fact, informants told us quite the opposite – funders tend to provide monies for each issue separately, leaving agencies applying for different pools of funding for each issue. For example, funding for anti-violence services tends to come from social, housing or criminal justice ministries while mental health and substance use programs are housed under health ministries. Services for any of these three issues directed towards Aboriginal peoples may be under ministries or government bodies for Aboriginal programming. And, as one informant pointed out, the federal government funds immigration and citizenship and provincial governments fund health care which creates gaps in service for refugee and immigrant women. As a result, there are few, if any, mental health services specific to this population in most regions. Counselling services available via settlement services are often geared towards people who have experienced war trauma or torture, not violence in relationships. The fact that mental health and substance use are often funded by different ministries than the anti-violence sector creates and exacerbates existing gaps in services. Each ministry has different ideas about, and expectations for, the services they fund and may not always communicate with one another or plan for collaborative services. This in turn contributes to a lack of collaboration between services the ministries fund.

Perhaps because of the situation of these sectors under different ministries, workers in each sector are not always held in the same regard. Informants indicated that anti-violence services and advocates tend to be particularly underfunded compared to the mental health and substance use sectors even though the respondents felt that these services are essential to

getting at the issues of violence often underlying women’s mental health and substance use concerns. Indeed, anti-violence advocates support and advocate for women in various aspects of their lives and this support has been shown to be central to reducing concerns around mental wellness and substance use (see overview). Pay disparities sometimes lead anti-violence advocates to feel undervalued and underappreciated for the work they do and may position mental health and substance use providers as ‘experts’ or ‘professionals’ to be deferred to by anti-violence advocates. Certainly the medical model that has traditionally informed the health fields (including mental health and substance use) has been favoured over feminist, empowerment-based frameworks in discussions about and programming for women with these intersecting concerns. This favouring, despite the evidence supporting the importance of

addressing violence for women with varying levels of mental health and substance use, may be contributing to rifts between the sectors as well.

The current focus on short-term funding cycles is detrimental to the development of stable and sustainable programming for women who have experienced violence and who have mental health and/or substance use concerns.

The informants also felt that the current preference for short-term funding cycles by government ministries and private granting foundations is detrimental to the development of stable and sustainable programming for women who have experienced violence who have mental health and substance use concerns. Short-term funding cycles make it difficult for agencies to plan long term, to secure and maintain qualified and competent employees and to provide the time necessary to develop and sustain meaningful and lasting partnerships and collaboration. This fiscal uncertainty leads administrators to spend a significant amount of time searching and applying for funding and takes time away from developing and providing quality programming. Moreover, women who take part in pilot projects or programming lose out when a program they

engage in finally that feels like a fit for them and that has demonstrated benefits no longer exists because it has come to the end of a funding contract.

The current focus on upstream prevention activities was also identified as problematic by informants. While some informants spoke about the importance of doing empowerment-based prevention work with girls and young women that is situated in their own contexts, this focus is diverting resources from women who are the most marginalized and in most need of resources. In addition, much of the funding for prevention of mental health and substance use concerns does not provide for addressing prevention of violence against women, which has been shown to be a major contributor to mental health and substance use concerns for women.

Finally, informants believed that there should be more recognition on behalf of funders of the time and resources that meaningful collaboration requires. Anti-violence, mental health and substance use services are generally under-resourced and there are often lengthy waitlists for

programs, whether residential or community-based. This is especially true for rural and remote communities where there may be few, if any, services for these concerns. Due to the focus on front line services in funding outcomes, there is often little time left to build relationships and foster collaboration across sectors. In this context, individual employees often work off of the sides of their desks to support collaborative initiatives they feel are beneficial for the women they serve. As a result, meaningful agency-wide collaboration across sectors is often compromised as information about the initiatives may not be shared extensively or as workers move on to other positions or agencies and the agency is no longer attached to the collaboration.

Informant Interview Themes – Policy Gaps

- ◆ *Generally, public policy is not violence-informed nor created using a gender-based analysis*
- ◆ *Many public policies contribute to rather than reduce harms to women*

When asked, informants generally could not identify any public policies that have impacted services for women who have experienced violence and who have mental health and substance use concerns. In fact, most informants stated that public policy has not evolved to recognize the connections between these issues and, as a result, often causes further harm to women (see Overview section). Still, there is legislation in Canada that could encourage more responsive and inclusive anti-violence services for women with varying levels of mental health and substance use. For example, many provinces and territories have provincial human rights legislation preventing service providers from excluding people from programming based on their health status and some even clearly position mental health and addictions as health conditions.

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 includes dependence on alcohol or a drug.⁸⁸ 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.⁸⁹ Beyond our national legislation, the United Nations Universal Declaration of Human Rights, which Canada helped to 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.⁹⁰

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”.⁹¹ The language and frameworks used in these pieces of legislation encourage mental health and substance use to be seen as health concerns and, possibly, as health impacts of violence, just as physical injuries are.

D. Key Learnings/Recommendations

Informant Interview Themes – Recommendations for Improvement

1. Focus needs to be placed on creating and enhancing services, projects and collaborative initiatives that respond to violence against women, mental health and substance use
2. Services in all three sectors need to be violence-informed or, at the least-trauma informed.
3. All relevant agencies/ministries need to be involved in meaningful collaboration – not only representatives from frontline anti-violence, mental health and substance use sectors.
4. Resources should be directed towards the women who are the most marginalized or who are most in need of them
5. Women with lived experience need to be included in any collaborative initiatives around violence, mental health and substance use in the lives of women

As has been discussed throughout this report, there is a need to develop and enhance research, collaborative initiatives and services designed to respond to women’s experiences of violence, mental health and substance use. There are a growing number of initiatives across Canada, but to date these efforts have been largely regional and sporadic, the product of a small group of agencies or health authorities to meet the needs of women in one region or community, although we are starting to see some larger, sustainable and provincial initiatives (see Appendix C for examples of some promising initiatives around Canada). Training on the connections between these issues is needed at all levels – government policy makers and funders, administrators and front line service providers. Yet, generally, this scan indicated that there is a severe lack of funding for initiatives specifically focussing on violence, mental health and substance use concerns. Informants identify this as a key gap that needs redressing.

Education and collaboration, informants stated, needs to begin at the level of ministries as these funders of anti-violence, mental health and substance use services are currently

operating from frameworks and in ways that lack coordination and are sometimes even in contradiction with one another. There is a need to bring ministries and policy makers together to have meaningful dialogue and collaborate planning with one another and with the various services women access around these issues. In addition, informants overwhelmingly stated that funders, program administrators and service providers need to have a better understanding of the impacts of violence on women, but also of how their decision making and services can cause further harm to women.

To foster greater understanding of the connections between violence, mental health and substance use informants argued that policy makers, funders and service providers need to take a violence-informed or, at the very-least, a trauma-informed approach to services for women. Using a trauma-informed framework, service providers assume that anyone accessing services could have been, at some point in their lives, exposed to violence or some other form of trauma. Starting from this assumption, service providers create relationships and offer support in ways that, at a minimum, do not further harm or re-traumatize people accessing services. ‘Trauma-informed’ approaches are popular among mental health and substance use professionals who find the framework useful for the various populations they work with.⁹² Many anti-violence advocates and feminists, however, argue that trauma-informed services do not go far enough to integrate a gender-based analysis.

Given the high percentage of women who experience violence in Canada, many anti-violence advocates and researchers prefer a ‘violence-informed’ approach to supporting women. These advocates feel that the trauma-informed framework is too general and does not focus enough on the various forms of violence and oppression women are subjected to at the hands of men. Using this framework, service providers assume that any woman accessing service has likely experienced some form of violence in her lifetime. Service providers take into consideration that a woman may be experiencing the wide-ranging short and long term effects of violence whether she discloses experiences of violence or not. A women-centred approach to support is recommended in this framework; women are seen as the experts of their own lives and are, at the very least, treated as partners in any plans for support or treatment.

Promising Philosophies Identified in this Scan	
Women-Centred	Women are treated as experts of their own lives and are supported around the concerns they identify as important in ways that are respectful and responsive to their lived experiences; Services ‘meet women where they are at’, not imposing any one goal or set of goals but supporting women around the concerns they identify and in ways that make sense and fit for them. In addition initiatives geared towards women who have experienced violence with varying levels of mental health and substance use should be guided by women with lived experience around these concerns. ⁹³
Anti-Oppression	Service providers work to be consciously aware of the various forms of

	oppression women may experience related to their social context (gender, ethnicity, sexual orientation, age, geographical location etc.) and set out to work in ways that do not further contribute to the oppression. ⁹⁴
Integrated & Holistic	Recognize and respond to the connections between violence against women, mental health and substance use. ⁹⁵
Relational	Service providers focus on the relationship between the service provider and the woman accessing services as well as developing peer support opportunities. ⁹⁶
Harm Reduction	Anti-violence advocates support women to reduce harms from experiences of violence, including the violence itself but also poverty, homelessness, mental health and substance use and other effects of violence against women ⁹⁷
Low Barrier	Efforts are made to get and keep women in services rather than to screen women out and resources are directed towards the women who are most marginalized and most in need of services.
No Wrong Door' Approach	Workers need not be 'experts' in all three fields, but no matter which service a woman enters she should encounter supporters who are in tune with the connections between violence, mental health and substance use. Service providers use knowledge of the connections to provide violence-informed care and collaborate with or refer women to other, violence-informed programming that can meet all their needs. ⁹⁸
Housing First Approaches	Focus on providing housing first then providing services as desired for the woman. This framework is based in evidence that stressors that impact mental health and substance use may be minimized when women have access to safe and affordable housing and thus housing needs to be a first priority. ⁹⁹

E. Conclusion

Currently, women in Canada who have experienced violence who have varying levels of mental health and/or substance use are often unable to access support that recognizes and responds to their lived experiences of the connections between these concerns. This review revealed large funding and policy gaps at the systems-levels across various provincial, territorial and federal ministries that fund public services women access. There is much work to be done on behalf of government ministries to better acknowledge, understand and respond to the needs of women who have experienced violence with mental health and substance use concerns. And in public and non-profit services for women there is much work to be done to recognize the

impact violence has on mental health and substance use and to provide more holistic, nonjudgmental services to women impacted by these intersecting issues. Violence-informed education and training on the connections and promising philosophies for supporting women is needed from the front line to the ministerial and systems levels.

Still, there are an encouraging and growing number of regional and provincial collaborative initiatives – whether training, education and services - from services providers, regional health providers and some ministries in some areas of the country, most notably Ontario and British Columbia. Resources, supports and funding are needed to enhance and sustain these current initiatives and to develop new, innovative ways of working to better support women.

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APPENDICES

Appendix A: Glossary

Anti-Violence/Violence Against Women Services

Refers broadly to agencies, programs and services for women who have experienced violence and the agencies that provide support to frontline service providers. These include, but are not limited to, Transitional Housing programs, counselling programs, sexual assault centres, women's centres, health-based domestic violence programs, victim service programs and provincial umbrella organizations supporting these various programs.

Mental Health

Mental health exists on a continuum, yet we tend to focus only on mental illness. The mental health 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 and therefore we all have some level of mental health. Mental health 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 health, 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 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 depend, however, on the substance we are using. Although the harmful health effects of illicit substances tend to appear more quickly than some legal substances, alcohol and tobacco, for two examples, can have lethal long-term health consequences. In addition, it is just as possible to overdose on prescribed medications or to become overly reliant on a legal substance (like caffeine). In short, the legality of a substance does not necessarily predict where we fall on the continuum.

Throughout this report the terms "women with mental health and substance use concerns" and "women with varying levels of mental health and/or substance use" are used. We avoid using terms like "problematic substance use" or "mental illness" because we feel that women are often labelled with these terms with no consideration of whether they feel the labels fit. While some women feel clinical diagnoses fit well and explain their experiences, others may not. We believe that the best option, when working with women, is to explore the language they prefer.

Transitional Housing Program

Refers broadly to Transition House, Second and Third Stage House and Safe Home programs (also known as Interval Houses and Women's Shelters in some regions). We use this term in recognition that shelter is just one aspect of Transitional Housing programs. These programs provide a number of other services and supports to women, including but not limited to advocacy, transportation, support, child care, prevention efforts, etc.

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 health 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.^c

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 behavior directed at women and girls because of their sex. Violence against women hinges on control and domination. A woman’s experiences with violence are shaped by her social context.

^c Godard, L., Cory, J., Abi-Jaoudé, A. (2008). *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health*. Retrieved April 15, 2010, from http://www.bcwomens.ca/NR/rdonlyres/8D65CADE-8541-4398-B264-7C28CED7D208/28333/BuildingBridges_ExecutiveSummary_Final.pdf

Appendix B: Description of Reducing Barriers and Building Bridges

Reducing Barriers to Support for Women Who Experience Violence

In 2008, BC Society of Transition Houses secured a grant from Status of Women Canada for a project (originally called “Opening Doors”) to develop a more coordinated approach to services for women fleeing violence with varying levels of mental wellness and substance use in Transition House, Second Stage and Safe Home programs in BC and the Yukon. The project is guided by a Working Group comprised of women with lived experience and representatives from the anti-violence, mental wellness and substance use fields as well as the funder of Transitional Housing programs in BC.

The project involves learning about current practices and challenges in BC, reviewing promising practices in Canada and Internationally, learning about current practices in BC and consultations with women about their experiences with and recommendations for Transitional Housing programs in BC. The end product of the Reducing Barriers project will be a toolkit for Transitional Housing programs 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 training has also been developed to compliment the toolkit. As of January 2011, six Transitional Housing programs across BC are piloting the Promising Principles and Practices. The project will be completed by August 2011.

Reducing Barriers Discussion Paper

http://www.bcsth.ca/sites/default/files/ReducingBarriersDiscussionPaper_Final.pdf

Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health

As a provincial leader in woman abuse and women’s health, the Woman Abuse Response Program (WARP) at BC Women’s Hospital and Health Centre identified the need to further our knowledge and improve the response to the intersecting issues of abuse and substance use and/or mental ill health in the lives of girls and women in BC. To achieve this, WARP engaged in preliminary province-wide consultations and educational forums with over 1000 community and health care stakeholders beginning in 2006. This led to the initiative *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health*.

In 2008, with funding from BC Women’s Hospital and Health Centre, Vancouver Foundation and MOMentum, the Woman Abuse Response Program advanced the work of the Building Bridges initiative by conducting a province-wide consultation. Since October of 2008, WARP has conducted standardized, cross-sectoral consultations and individual interviews with 460 service providers and policy leaders primarily from the anti-violence, addictions, mental health, and health care sectors, with participation from some community, child protection and social service organizations. As well, the team conducted 13 focus groups across BC (n=100) among

women who had experiences of abuse and substance use and/ or mental health issues. The primary purpose of this consultation was to systematically gather information about whether services in BC were meeting the needs of women who have experiences of abuse and substance use and/or mental health issues. The findings will be used to develop a provincial framework that will inform policy, funding and program planning for services that support women impacted by these three issues.

Building Bridges Consultation Summary Report

http://www.bcwomens.ca/NR/rdonlyres/C1AA97BC-FAAB-40E9-972D-F377EE729080/45188/BB_summaryreport.pdf

Appendix C: Informant Interview Questions

1. What are the service gaps that you have experienced?
 - Why do you think they exist?
2. What do you think is needed to address those gaps?
3. Do you know of any public policy or funding changes that have impacted services?
4. Are there any changes in policy or funding you think would improve service?
5. Do you know of any collaboration across sectors that has improved service?
 - If yes, do you know who funds those initiatives?
6. Could you make any recommendations for what kinds of collaborations would increase service availability?
 - Can you think of anything else that is needed to increase service availability?
7. What gets in the way of collaboration?
8. Can you think of any capacity building initiatives or training that has changed or could change the field?
 - What do you think is valuable/transferrable in those initiatives?
 - Do you know who funds these initiatives?
9. Have any important organizations or resources been created in the last five years?
10. Have any important organizations or resources been lost in the past five years?

Appendix D: Sample of Initiatives and Resources in Canada

Sample of Current or Recent Initiatives and Resources Across Canada*

Province/Territory	Initiative/Resource	Agency(ies)/Organization(s)	Funder(s)	More Information
Nova Scotia [‡]	Regional based initiatives to strengthen services			
Prince Edward Island	Developing a position to provide mental health services for women	PEI Family Violence Prevention Service	TBA	http://www.fvps.ca/
Newfoundland and Labrador [‡]				
Quebec	Training, advocacy and support for low barrier programs	Fédération de ressources d'hébergement pour femmes violentées et en difficulté du Québec		http://www.fede.qc.ca/
Ontario	<i>Connections</i> – groups for women that address the impacts of domestic violence for substance-involved mothers	Mothercraft (part of Breaking the Cycle)	Ontario Ministry of Attorney General (piloting); Ontario Ministry of Children and Youth Services (Ongoing)	http://www.mothercraft.ca/resource-library/publications/BTC_Compendium_2007.pdf
	Family Violence Project of Waterloo Region – a collaboration of agencies that provide wraparound services for people who have experienced domestic violence	Various; Operates out of Mosaic Counselling & Family Services	Ontario Ministry of Attorney General	http://fvpwaterloo.ca
	Jean Tweed Centre – women-centred program where women can address their substance use and problem gambling; have outreach workers in various other programs/sites	Jean Tweed Centre for Women & their Families	Local Health Integrated Network	www.jeantweed.com

	Woman Abuse Screening Project – engaging regions throughout Ontario in collaborating across sectors to implement screening for woman abuse, sexual assault and trauma in mental health and addiction agencies (also is creating opportunities for cross-training and closing gaps in services)	Various – began in 5 communities and is growing; community networks create their own project specific to the community	The Ontario Trillium Foundation	http://womanabusescreening.ca/en/about/mandate
	Tripod Project – groups for women impacted by violence, mental health and substance use	Part of Woman Abuse Screening Project		
	My Sister’s Place – A women only, daytime space for women who are homeless or at risk of homelessness can participate in programs and access resources from about 18 different agencies	WOTCH Community Mental Health, London Ontario		http://www.mysistersplace.ca/
	Development of training curriculum for frontline anti-violence, mental health and substance use workers across province	Violence and Health Research Program, University of Toronto	Ontario Ministry of Citizenship and Immigration; Ontario Women’s Directorate	
	Development of tools and training for Interval and Transition House workers for supporting women with mental health labels; Short film on substance use and harm reduction for VAW workers	Ontario Association of Interval and Transition Houses		
	Project to review literature on 3 issues, create information pamphlets for French women, create intervention tools and training for French VAW workers	Action ontarienne contre la violence faite aux femmes	Société Santé en Français	www.francofemmes.org/aocvf
Manitoba [¥]				
Saskatchewan [¥]				

Alberta	Discovery House – a Second Stage program that provides wrap around services for women who have experienced violence		Calgary Homeless Foundation; Family & Community Support Services; Government of Alberta	http://www.discoveryhouse.ca
British Columbia	<p>Building Bridges – brought service providers together across various sectors to talk, learn about and plan for services for women impacted by violence, mental ill health and substance use</p> <p>Quicklinks and Quicksteps – guides providing information about the overlapping issues and steps to collaboration across sectors</p> <p>Making Connections – development and piloting of a curriculum for groups for women in Transitional Housing programs co-facilitated by anti-violence and mental health advocates</p> <p>SHE Framework: Safety and Health Enhancement for Women Experiencing Abuse – helps health providers assess and plan for services that help vs harm women</p> <p>Women-Centred Care: A Curriculum for Health Care Providers</p>	<p>Woman Abuse Response Program at BC Women’s Hospital & Health Centre</p> <p>Woman Abuse Response Program at BC Women’s Hospital & Health Centre: South Peace Community Resource Centre</p> <p>Woman Abuse Response Program</p> <p>BC Women’s Hospital & Health Centre; Vancouver Coastal Health</p>	<p>BC Women’s Hospital & Health Centre; Vancouver Foundation</p> <p>Canadian Women’s Foundation; Canada Post Mental Health Foundation</p> <p>BC Women’s Hospital & Health Centre; BC Institute Against Family Violence</p> <p>BC Women’s Hospital & Health Centre; Vancouver Coastal Health</p>	<p>http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm</p> <p>http://www.whrn.ca/documents/aaSHEFramework.pdf</p> <p>http://www.whrn.ca/documents/aaCurriculumforWomenCentredCareFinal.pdf</p>

	<p><i>Freedom From Violence: Tools for Working with Trauma, Mental Health and Substance Use</i> – a toolkit for Stopping The Violence Programs</p> <p><i>You Are Not Alone: Violence, Substance Use and Mental Health</i> – a film and workbook to generate discussion about safety from violence, and about substance use, mental health and survival sex work.</p>	Ending Violence Association of BC	<p>Vancouver Foundation; BC Ministry of Community Services</p> <p>Vancouver Foundation; Canadian Women’s Foundation</p>	<p>http://endingviolence.org/node/459</p> <p>http://endingviolence.org/node/850</p>
	<p><i>“Me, I’m Living It”: The Primary Healthcare Experiences of Women Who Use Drugs in Vancouver’s Downtown Eastside</i></p>	Vancouver Area Network of Drug Users; Women’s Health Research Institute; The University of British Columbia; BC Centre of Excellence for Women’s Health	Michael Smith Foundation	http://www.bcwomens.ca/NR/rdonlyres/C1AA97BC-FAAB-40E9-972D-F377EE729080/36939/MeImlivi.git.pdf
	<p>Coalescing on Women and Substance Use Virtual Community – the result of virtual communities of practice that started during the <i>Coalescing on Women and Substance Use project</i>. The site shares and promotes action on promising approaches to responding to substance use by girls and women.</p> <p>What is Trauma-Informed Care webinars</p> <p>Understanding developing trauma-Informed care in health care services – a project to create dialogue and understanding of trauma-informed care in health settings</p>	British Columbia Centre of Excellence for Women’s Health	BC Centre of Excellence for Women’s Health; Canadian Women’s Health Network; Canadian Centre on Substance Use	http://coalescing-vc.org/index.htm
	<p>Reducing Barriers to Support for Women Fleeing Violence – a project to produce a toolkit and training for Transitional Housing programs</p>	BC Society of Transition Houses	Status of Women Canada	http://www.bcsth.ca/content/educating-barriers-support-women-who-experience-violence

	Maxxine Wright Place - supports women who are pregnant or have very young children (under the age of 2 at intake) and who are impacted by substance use or violence	Atira Women's Resource Society; Fraser Health; Ministry for Children and Family Development; OPTIONS: Services to Communities		http://www.atira.bc.ca/maxxine.html
	Sheway - a partnership initiative bringing government and community together to provide comprehensive health and social services to women who are either pregnant or parenting children less than 18 months old and who are experiencing current or previous issues with substance use		BC's Children's Hospital; Vancouver Coastal Health; Ministry for Children and Family Development; YWCA; Vancouver Native Health Society	http://www.bccewh.bc.ca/publications-resources/documents/shewayreport.pdf
	Fir Square – first in Canada to care for substance-using women and substance-exposed newborns on the same unit	BC Women's Hospital & Health Centre		http://www.bcwomens.ca/Services/PregnancyBirthNewborns/HospitalCare/SubstanceUsePregnancy.htm
	Aurora Centre – provides both day and residential treatment for women; helps women make links between their substance use and other issues in their lives	BC Women's Hospital & Health Centre		http://www.bcwomens.ca/Services/HealthServices/AuroraCentre/default.htm
	Victoria Women's Sexual Assault Centre – a support group from women based on Najavits' Seeking Safety model			https://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/highs_lows_ch31/Documents/highs_lows_ch31.pdf
	Herway Home – housing and integrated support services for women and children with complex lives	Over 30 agencies, 2 ministries, 85 individuals	Queen Alexandra Foundation for Children (initial funding)	http://www.whrn.ca/documents/HerWayHome.pdf
	Peggy's Place – a transition house for women disabled by mental illness who have experienced violence	Kettle Friendship Society		http://www.thekettle.ca/programs.aspx

	<p>IMPART – The Intersections of Mental Health Perspectives in Research Training A research training program designed to equip health researchers from across disciplines, sectors and settings to conduct gender- and sex-based analyses in addictions research with a focus on the intersections of violence, trauma and mental health with addictions</p>	<p>BC Centre of Excellence for Women’s Health; University of British Columbia; BC Women’s Hospital & Health Centre</p>	<p>Canadian Institute of Health Research</p>	<p>http://www.addictionsresearchtraining.ca/</p>
General trends	<p>Canadian Mental Health Association teaming up with Transition Houses to provide mental health support for women</p> <p>Hospitals, health programs and health regions doing education around trauma-informed practices</p>			

* These initiatives were brought up by our informants during interviews. Although we did our best to reach out to anti-violence programs across the country, there may be other promising initiatives that did not come up and that we, therefore, have not reported here
¥We did not hear of nor find any specific initiatives from these regions