5.1 Historical Perspectives on Violence Against Women in BC

By Sarah Leavitt

5.1.1 Introduction

Organized responses to violence against women began in Canada and BC in the 1960s with feminist activism. At that time, the common point of view about violence against women, both in society and in the legal system, was that it was a private matter, that it was a normal and acceptable way for men to treat women, that women were to blame for being assaulted, or even that most or all claims of violence were untrue.

Public understanding of violence against women has increased and policies and legislation have, in many cases, improved. However, violence against women continues to be a widespread and serious problem. Attitudes and beliefs that condone or ignore violence, as well as social conditions such as poverty and lack of resources, contribute to the continuation of violence.

Throughout the 70s, 80s and 90s, sexual assault centres, women's centres, transition houses, counselling programs and victim services programs were developed in BC to respond to violence against women. Most of these programs drew on feminist research and writing as they developed their understanding of violence against women and their approaches to counselling and advocacy. Anti-violence programs have also drawn on anti-oppression theory, a wide range of counselling approaches, popular education techniques and other sources as they have developed. For example, Judith Herman made significant developments in the approach to trauma work, shifting the focus from breaking the silence and telling our stories to staged trauma counselling work.

In many programs, workers have moved from a peer counselling approach to a more standardized or professionalized way of working. This has helped programs gain credibility with government and other sectors, although there have also been suggestions that this has taken away from the grassroots nature of feminist intervention and analysis. However, despite increased professionalization, the feminist values of empowerment through listening, understanding and following a woman's needs remain the core of the programs. Workers and trainers in the anti-violence field are engaged in an ongoing process of integrating clinical skills with feminist approaches.

As society and government have become more educated about violence against women, important improvements have been made to policy and legislation. However, in recent years there have been significant cuts to many anti-violence programs, as well as to income assistance, housing and other essential parts of the social safety net. Anti-violence workers are finding that the women they work with face more serious and complex challenges to surviving, including extreme poverty, lack of housing, mental health issues and substance use issues.

Throughout the last few decades, innovations have been made in counselling and advocacy techniques, training and support for workers, resource development and public education. Training programs have been developed that specifically address the intersections of violence, mental health and substance use. Anti-violence workers are increasingly aware of the ways in which substance use and mental health issues affect a large number of survivors of violence.

Anti-violence organizations have made concerted efforts to build and participate in cross-sector coordination initiatives in order to improve relationships with other sectors such as police, Crown, health, addictions and multicultural and Aboriginal agencies. Efforts have been made to make services accessible to all women, including women who are oppressed by racism, homophobia, poverty, ageism and ableism. Services have also been developed that serve specific communities, such as Aboriginal people, lesbians, older women and immigrant women. Despite the enormous challenges facing the anti-violence sector, services and approaches to violence continue to develop and women's organizations remain one of the primary resources for women facing violence.

5.1.2 Some Key Dates In The History Of Anti-Violence Work In Bc

Taken from *Significant Events in the Development of Effective Responses to Victims of Crime and Violence Against Women, Children, Seniors and People with Disabilities in BC, Canada and Internationally,* by Linda Light (2000); *Events Impacting Community Coordination on Violence Against Women,* by Community Coordination for Women's Safety (2002); and *Victims of Crime Victim Service Worker Handbook*, by the Justice Institute of BC and MPSSG (in press 2007).

1965	*Criminal Code of Canada* is amended so that women do not have to prove a greater level of injury if they are assaulted by a partner than if they are assaulted by a stranger.
1972	The first sexual assault centres and transition houses are established in BC. The BC government passes the *Criminal Injuries Compensation Act,* allowing victims of crime who have suffered personal injury to apply to the Workers' Compensation Board for compensation.
1973	The first victim assistance programs are organized by police departments in various Canadian cities. BC's *Child and Family Services Act* is implemented to protect children from physical and sexual abuse.
1974	The first police-based victim services begin operating in BC.
1976	The United Way of the Lower Mainland sponsors the Symposium on Family Violence, and the first treatment program is set up for men who batter.
1978	BC/Yukon Society of Transition Houses is founded.
1980	The Canadian Advisory Council on the Status of Women publishes *Wife Battering in Canada: the Vicious Circle*, by Linda McLeod, and Vancouver Women's Research Centre and Vancouver Transition House publish *Battered and Blamed: A Report on Wife Assault from the Perspective of Battered Women.*
Early to mid 1980s	A strong network of victim support programs grows out of grassroots activity to provide justice-related support to victims of crime

1982	MPs laugh when MP Margaret Mitchell (NDP, Vancouver East) raises the issue of battered women in the House of Commons. *Wife Battering: A Report on Violence in the Family* is submitted to Parliament. The Solicitor General of Canada directs RCMP to pursue charges in cases of relationship violence where there are reasonable and probable grounds. RCMP develops national charging policy.
1983	*Criminal Code of Canada* offence of rape is changed to sexual assault to parallel physical assault provisions, emphasise the violent nature of the crime, delete the requirement for corroboration in sexual offences and make it a crime for a man to sexually assault his wife. Peter Jaffe and Carole Ann Burris publish the results of a study: *Wife Abuse as a Crime: The Impact of Police Laying Charges.*
1984	The Solicitor General of Canada provides funding to select police agencies across Canada for police-based victim assistance programs, including Vancouver and New Westminster. The BC Ministry of Attorney General Wife Assault Policy is implemented, the first of a series of BC policies guiding justice system responses to violence against women and children.
1985	National Women's Legal Education and Action Fund (LEAF) is established.
1986	The BC Ministry of Attorney General's study of its policy recommends "increased use of arrest, police/Crown counsel/ Corrections networking, efforts to address reluctant witnesses through Victim Support Workers, RCMP/municipal police joint training, municipal police record-keeping to parallel that of RCMP, and Crown record-keeping to compare statistics on RCC's (reports to Crown Counsel) recommending charges and charges approved." Revisions are made to the policy based on these recommendations.
1987	The BC Victim Assistance Program is established, incorporating existing programs. Police-based programs are increased and community-based programs are funded to serve women and children victims of violence. The first Crown-based program is established.
1989	The BC Wife Assault Coordination Program is established, providing funding to six communities to set up local coordinating committees. This is in addition to Victoria, where the coordinating committee is already funded.
1990	Three Aboriginal victim assistance programs are established in BC. The budget for the Secretary of State Women's Program (which provided funding to many grass roots feminist organizations including shelters) is reduced from 12.7 million to 9.2 million.
1991	The first community-based victim support program for multicultural victims of crime is established.

1992 Family Violence Research Centres is established.

The BC Association of Specialized Victim Assistance and Counselling Programs is established.

BC Women's Programs launch the first media campaign and public information pamphlet against violence against women.

Is Anyone Listening?, the report of the BC Task Force on Family Violence, is published.

1992 Ten million dollars of funding is approved for the new Stopping the Violence initiative, including funding for 80 new counselling programs for women, increased funding for community-based victim assistance in the form of funding for new Sexual Assault/Woman Assault programs and the first province-wide program for children who witness abuse.

An *Act to Amend the Criminal Code* (sexual assault) restores protections for sexual assault complainants by restricting questioning on sexual activity (rape shield), defines consent and restricts the defence of "honest belief" in consent.

Criminal Code of Canada is amended to include criminal harassment.

BC's *Wife Assault Policy* is revised and updated as the *Violence Against Women in Relationships Policy*.

1993

The "K file" designation is introduced to help track and monitor vawir cases.

BC Ministry of Attorney General establishes Victim Services Division (now Victim Services and Crime Prevention Division of the Ministry of Public Safety and Solicitor General).

BC's *Victims of Crime Act* is amended to include stalking and threats.

The Protection Order Registry is introduced, including certain types of civil and criminal orders. Access restricted to police.

1995 *Criminal Code* amendments are proclaimed that make peace bonds easier to obtain and more effective and increase maximum penalties for breaches.

The *Criminal Injury Compensation Act* is updated to include criminal harassment, uttering threats, criminal injuries at work and support for immediate families of deceased victims.

The BC Provincial Health Officer's report identified freedom from violence as necessary for the health of British Columbians.

1996	In Vernon, BC, Marc Chahal murders eight members of his ex-wife Rajwar Gakhal's family and kills himself. Justice Josiah Wood heads an inquest into the killings that results in recommendations for better response by the police and justice system to violence against women. *An Act to Amend the Criminal Code* (sentencing) is proclaimed, including requiring the court to consider a victim impact statement and providing that abuse of a spouse or child, or abuse of a position of trust, shall be considered an aggravating factor in sentencing. Crown Victim Witness services are doubled. BC's *VAWIR Policy* is amended to include criminal harassment. The first Domestic Violence Unit is established, in the Vancouver Police Department, with counsellors and police officers working together on high-risk domestic violence cases.
1997	*An Act to Amend the Criminal Code* (production of records in sexual offence proceedings) is proclaimed, restricting the production to the accused of irrelevant personal records. The Federal Family Violence Initiative reduces its funding from $136 million in 1991 to $30.7 million.
2001	The Community Coordination for Women's Safety Program is started by a partnership between the BCASVACP and Victim Services Division.
2002	The *Crime Victim Assistance Act* comes into effect in BC, replacing the *Criminal Injury Compensation Act.* BC's Crown Victim/Witness Services are eliminated and funding is cut to sexual assault programs and women's centres, along with numerous other cuts and changes to legislation affecting violence against women in BC.
2005	Bill C-2 introduces *Criminal Code* amendments expanding testimonial aids and protection for vulnerable witnesses.

5.2 History and Contribution of the Mental Health and Addiction Sectors

By Tessa Parkes

Introduction

> *"In British Columbia, addictions, mental health and primary care services were for many years delivered as separate systems under different ministries, with little opportunity for coordination. … Even when both disorders have been identified, treatment is difficult, since traditionally, the two systems have differed in philosophy and approach"* (Richter 2004).

In this section of the tool kit we discuss the major historical and philosophical developments in each sector, the key ideas and priorities that are most current, and what services are currently comprised of. We also discuss the most significant and relevant contributions of each, acknowledging that the two sectors have historically operated separately and in isolation of each other.

5.2.1 Mental Health Services: Historical And Philosophical Developments

> *"People with mental illness, their families, and the mental health professionals who try to support them are currently in a state of dynamic tension. At no other time in history have there been in place the knowledge and understanding, the range of techniques, and the human resources to create the kind of revolutionary change in the lives of consumers that is now possible. New therapies, the emergence of evidence-based programs, a new awareness of population health factors, and consumer and family empowerment all contribute to this powerful mixture. The source of tension is clear. It can be found in the gap between what we know we can do and what we are actually doing. We can intervene early in psychotic illness and dramatically improve its course, but in most cases we do not. We can house people effectively in ways that support independence and dignity, but in many cases we do not. We can support people in regular work and school settings, but in most cases we do not. We know that consumers can help each other if they have the resources, but in most cases they do not. The list could be longer"* (Trainor et al 2004).

History And Philosophical Developments: The Big Ideas

Mental health services were described as the "orphan child" of health care in Canada by the Romanow Commission's Final Report on the Future of Health Care in Canada (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). Many commentators have expressed concern about mental health and addictions being marginalized in health care, despite the huge social and economic implications,

and the fact that these problems are so widespread in Canadian society. There have been profound changes in the mental health system over the past 30 to 40 years; indeed, it has been described as being in a permanent state of reform (Arboleda-Florez 2005).

In most countries, the practice for many centuries was to send people viewed as "crazy" to asylums or mental hospitals that were located well away from urban centres.

Isolating people with mental health problems in rural asylums was known as the "custodial" model, and was based on an understanding of mental health problems/mental illness/madness as being incurable and the people afflicted as out of control, frightening and depraved. Over time, driven by new ways of viewing people with mental health problems, a desire to cut hospital costs, and new medications, this model gave way to the "deinstitutionalization" model.

Deinstitutionalization started in the 1950s and rapidly took hold in the 1970s, 1980s and 1990s, with the closure of long-stay hospitals and the discharge of patients into the community. Concepts such as empowerment, client/patient rights and citizenship began to be applied to this very marginalized and excluded group of people. These changes were undertaken as a health policy priority, but adequate planning and much-needed resources did not follow the hospital closures into the community: *"Beds were closed and psychiatric patients were effectively dumped on the streets with very little access to the needed supports"* (www.mooddisorderscanada.ca/social/senate/index.htm). While the sentiments and intentions behind deinstitutionalization were largely progressive, the result for many ex-patients was (and still is) homelessness, unemployment, poverty and victimization. Stigma and discrimination continue to make it very difficult for ex-patients to have a normal, valued community life.

Policy and practice in the mental health field has been in a state of change and flux for the last 50 years. New ideas about the causes and "treatability" of mental health problems/mental illness, alongside changes in the ways that people who experience these problems are viewed, have radically altered the landscape.

Although the "service paradigm" and medical model still predominate in most public mental health settings, there has been a steady progress over the past decade, at least, towards including and involving consumers and their families in the design and delivery of services. Consumers themselves have been developing and communicating their own ways of thinking and understanding their mental health for many years (see Church and Reville 1988; Church 1996). Consumer emphasized the importance of a number of factors for quality of life, including:

- financial security
- decent housing
- meaningful work or vocational and educational achievement
- effective, sensitive and supportive services,
- response by services to the specific needs of women and other minority groups
- having friends and intimate relationships
- the elimination of stigma and discrimination

In practice many women have limited access to mental health care services.

> **"Women consumers/survivors, where their voices have specifically been heard, are particularly concerned with needing mental health services that help them to deal with the following issues: victimization; parenting and child related issues; reproductive health, relationships and sexuality; menopause and aging; discrimination, rejection and isolation; loss and grief. They are adamant about the need for better access to non-medical interventions and a non-medical approach to their distress and life circumstances" (Cook, Jonikas and Bamberger 2002).**

5.2.2 A Gendered Critique Of Mainstream Mental Health Policy And Service Provision

As a rule, mental health services have been very poor at taking gender into account in the understanding and treatment of mental health problems. A gendered approach to mental health and the mental illness/psychiatric system has been variously influential over the past 30 or more years, despite the hard work and advocacy of the women's health movement in Canada. Authors such as Phyllis Chesler (*Women and Madness*, 1974), Barbara Ehrenreich and Deirdre English (*For Her Own Good: 150 Years of Experts' Advice to Women,* 1978), Susan Penfold and Gillian Walker (*Women and the Psychiatric Paradox*, 1983), and Jane Ussher (*Women's Madness: Misogyny or Mental Illness*? 1992), amongst others, have made significant contributions in drawing attention to the ways in which gender and gender inequity intersect with mental health. These feminist critiques emphasize the ways in which women have been pathologized and over-medicated, over-diagnosed and underserved by psychiatry since its beginnings. For example, the diagnostic categories used in psychiatry have been described as distorting or obscuring women's lived experiences rather than being aids to effective treatment (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

In 1987, a Canadian Mental Health Association (CMHA) report, *Women and Mental Health in Canada: Strategies for Change,* detailed a range of key mental health concerns facing women and emphasized some of the main causes, such as the feminization of poverty and violence against women, outlining 25 recommendations for improvement. A BC-produced publication, *Hearing Women's Voices* (Morrow and Chappell 1999), added to the debate by arguing that women's mental health could not be understood in isolation from the social conditions of women's lives. Other more conservative mental health/illness associations have now also joined the call for change by stressing the importance of understanding the social dimensions of women's mental heath. For example, in 1996 the World Federation for Mental Health stated that women's mental health could only be understood by considering the biological, social, cultural, economic and personal contexts of their lives (Stewart et al 2006). A range of publications from around the globe now testify to gendered differences in prevalence of, pathways to and expressions of mental distress and mental health problems, clearly pointing to the need for gender-specific planning and programming.

Contributions and critiques based on gender have, like those on race and culture and mental health/illness, been largely marginalized and discounted within mainstream psychiatry. This continues to the present day with the 2006 Kirby Report, the federal report on mental health, mental illness and addiction in Canada, remaining gender-blind in its analysis (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). Despite the well articulated calls for a women-centred approach to policy, program and treatment. There is little evidence of this being translated into practice.

Instead, most mental health services for women continue to take an overly medical perspective, influenced by mental health research that is biased toward men and research and policy that inadequately addresses

women's issues (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). The majority of mental health professionals lack specific training or knowledge about women's mental health or women's issues in general. Very few staff feel confident and competent in dealing with women's experiences of violence, abuse and oppression. Professional education and training still largely ignores or marginalizes the now extensive knowledge gathered on gender and gender inequality and the associated impacts on women's mental health.

Given that the mental health consequences of violence and childhood sexual abuse are so extensive, including posttraumatic stress disorder, anxiety, depression, panic disorders, self-inflicted harm, suicide, eating problems/ disorders, substance use, dissociative disorders and psychotic breakdown, it remains incredible that addressing these issues is still not prioritized in professional agendas.

In practice many women have limited access to mental health care services and have to contend with many barriers such as shortages of services/personnel, a lack of appropriate services for their needs, location or budget, and long waiting lists for more appropriate/community based services. Many women simply do not know where or how to access help for their emotional or mental health needs. Women with concurrent substance use problems, and who are Aboriginal, homeless, poor or in violent relationships, encounter even greater barriers in accessing services. Women who live in rural or Northern communities often need to travel long distances in order to receive help (http://www.mentalhealthconsumer.net/index-links.html). Women's responsibilities as mothers pose an additional barrier. Mothers (particularly those who are on welfare, who are single or who are in unsafe relationships) fear that they will lose custody or care of their children if they access mental health services (a realistic fear).

While there have been many advances in knowledge and theory, the medical model of understanding mental health problems remains dominant, especially within the formal public mental health system. Mental health services are situated within a psychiatric frame of diagnosis and medical treatment:

> *"The psychiatric profession remains closely tied to day-to-day care through the need for formal psychiatric evaluation to establish diagnosis, and the prescription of medication for symptom management" (Centre for Addiction and Mental Health 2002).*

Many interest groups are calling for radical change within mental health services, particularly for those groups least well served by the medical and psychiatric approach, including women (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

5.2.3 Main Contribution Of The Mental Health Sector

Taking a broader perspective on the mental health sector, one of its main contributions to the wider social welfare/support field has been the development of a strong survivor voice, which brings a new emphasis to issues of human rights, equality, empowerment, social justice and non-oppressive systems of treatment, support and care. While this critique is not having nearly as much impact as it could have, largely due to the continued strength of the dominant medical paradigm, the strong professionalization of the sector and the continued negative societal attitudes towards those with mental health problems, it is nonetheless a significant force for change.

A growing interest in trauma-informed care is another significant contribution being made by the mental health sector: acknowledging and responding to the links between child and adult experiences of violence and trauma and consequent mental health problems. How these developments change the mental health field over the next decade is hard to predict, but for women consumers/survivors it is clear that much change still needs to take place before the system becomes sensitive and responsive to their particular needs.

5.2.4 Current Configurations Of Mental Health Service Delivery

With a few exceptions[1], the funding, planning, delivery and evaluation of mental health services in Canada falls within the provincial mandate for health services. Hospital, community programs and physician services for mental health conditions are all publicly funded. Private counselling is not covered by most health care insurance plans. In Canada there is a close relationship between the mental health system and the criminal justice system. This is partly historical and partly due to the number of people, mostly men, with concurrent mental health and substance use problems.

The target population given most priority within current policy and practice are people diagnosed with severe mental illness (SMI) as opposed to individuals with mild or moderate problems. The term "severe mental illness" is used to designate those individuals with conditions that are particularly disabling, and is usually a result of the type of disorder (needs to be in the DSM-IV) and the level of functional impairment. "Functional impairment" means that the disorder substantially interferes with vocational capacity, creates serious interpersonal difficulties or is associated with a suicide plan or attempt at some time during the past 12 months. The DSM-IV defines as "severe" cases in which "many symptoms in excess of those required to make the diagnosis or several symptoms that are particularly severe are present, or the symptoms result in marked impairment in social or occupational functioning."

Certain diagnoses in and of themselves are considered to meet the criteria for serious mental illness without the level of functional impairment being considered. The ones usually included are:

- All cases of schizophrenia (a psychotic disorder)
- Severe cases of major depression and bipolar disorder (mood disorders)
- Severe cases of panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder (anxiety disorders)
- Severe cases of attention deficit/hyperactivity disorder (typically, a childhood disorder)
- Severe cases of anorexia nervosa (an eating disorder)

The rationale is that these disorders are so severe that they almost always lead to serious impairment if not treated. When advocating for a woman's access to mental health treatment, an advocate should outline how a woman's mental health concern is impacting her functionality (for more information, please see the sections Treatment Issues with Mental Health and Substance Use Problems, and Safety Planning for Women with Mental Health Issues).

In terms of the configuration of services, formal mental health services currently consist of various hospital, community agency and private practice based options. They are staffed by a range of professionals and para-professionals such as physicians, nurses, social workers, psychologists and occupational therapists, and have extended to providing services such as housing and vocational support as well as treatment. Family physicians, working alone, in groups or in conjunction with specialists, now provide the largest proportion of primary mental health care in Canada. There is an increased interest in providing shared care between family physicians and psychiatrists in order to enhance the capacity of primary care services to effectively address the mental health needs of their local populations (Centre for Addiction and Mental Health 2002).

1 Aboriginal people and other "status" populations have access to some federally funded programs.

Informal care (financial, social, emotional and practical) by families and friends also substantially contributes to the support received by those with mental health needs, despite almost no financial or practical supports. Again, a gendered perspective on informal care is important because of the high numbers of caregivers who are women. Caregivers significantly contribute to the care and welfare of others, with little support for their own needs and often to the detriment of their emotional/mental and physical wellbeing. Care in the community, the default policy position during and after deinstitutionalization, largely means people caring for themselves or being supported or cared for by female family members (Fast and Keating 2001). This is largely invisible in mental health policy and practice.

Key elements of services may include: case management, crisis response, housing, clubhouses, vocational/ educational/ employment support and consumer-run organisations and support groups/phone-lines. Assertive Community Treatment (ACT) teams are a fairly recent addition and are targeted primarily at people with severe mental illness coming out of psychiatric institutions into the community. Approaches to achieving a wide range of community services differ in rural and northern areas of Canada and BC, where a scarcity of resources and small populations dictate multiple professional and program roles (Centre for Addiction and Mental Health 2002). The range of community resources differs hugely from region to region and across urban and rural areas in BC.

For more information on specific treatments for mental health problems, please see Interventions for Mental Health and Substance Use Problems.

5.2.5 Substance Use/Addiction Services: Major Changes In Key Ideas And Ownership

> *"There are many passionate viewpoints as to the causal factors of addiction, how it can be prevented, the adequacy of resources, where the resources should be allocated and who should or should not manage the service delivery system. It is a subject area where almost everyone has experienced some impact in their lives and where everyone has an opinion. It is because of this that alcohol and drug services will always encounter tensions or a 'push-pull' in its service delivery focus and its organizational structure"* (Duffell 2004).

Alcohol and drug services have undergone enormous organizational and service delivery changes since their inception in the 1950s. At that time, treatment was mostly based on the self-help model associated with Alcoholics Anonymous (AA), and informed by an increasingly influential "disease model" of addiction that took over from the predominant "moral model" (Duffel 2004). The medical or disease model viewed addiction as caused by genetic and biological factors rather than weak or bad character, with the individual no longer personally responsible since the addiction was beyond their control. By defining addiction as a disease, a strong argument could then be made that individuals with these problems were deserving of treatment instead of criminals deserving punishment (BC Ministry of Health 2004). However, the disease of addiction was viewed as incurable and progressive, with any further use of the substance regarded as a relapse, whether or not it resulted in harmful consequences.

In the early 1970s in BC, alcohol and drug services were subsumed under a single Commission that took responsibility for all addiction services to the general population. However, the focus of this work was the criminal impact of addiction on society, rather than a focus on individuals with problems. It was during this period that the infamous methadone program and compulsory treatment of heroin users under the Heroin Treatment Act was instigated, allowing for the detention of users in BC's heroin treatment centre (Duffell 2004).

This unsuccessful approach was eventually discontinued and the Act repealed in 1982. Government then broadened the focus towards health, relocating addiction services under the Ministry of Health Alcohol and Drug Programs (ADP). Many changes occurred through the 1980s and 1990s, when policy documents pointed to the need for an increased focus on addiction services, better coordination of services and policy, and additional funds for prevention. Significant focus was brought to women's treatment in this period; women's day treatment programs were piloted and evaluated across the province and specialized women's residential treatment beds were consolidated at the Aurora Centre at BC Women's Hospital.

Since 2002, addictions service provincial policy has been located in the Ministry of Health Services and Health Planning and integrated with mental health into a Mental Health and Addictions Division. Policy direction for prevention is placed under the Population Health Division. With health care regionalization the five health authorities across BC are now responsible for alcohol and drug prevention and treatment program delivery, and an integrated system across mental health and addiction services is now emerging. In terms of women-centred care, merging mental health and addictions may turn out to be a good thing if the merger acquires a perspective that reflects the complexities of women's lives, the multiple contributors to mental illness or addiction, and the interactivity of treatment approaches (Greaves 2006).

5.2.6 Approaches To Treatment

Although there has been ongoing professionalization of the addictions field since the 1960s and 1970s, medical and psychiatric professionals now play a much less dominant role in assessment and treatment than psychologists, social workers and certified substance abuse counsellors.

Generally there is more emphasis on prevention and early identification in substance use/addiction settings than in the mental health sector.

Within substance use/addiction treatment and intervention settings there has been a tendency towards a one-size-fits-all approach to intervention; characterised by complete abstinence goals and a top-down, mandated, provider-set agenda. New approaches that avoid prescriptive and confrontational approaches and acknowledge a person's readiness and motivation for change (Miller and Rollnick 2002) are increasingly being utilized. These approaches are based on behavioural and social cognitive theories that suggest that addictive behaviour has multiple determinants and that individuals differ in risk depending on their own unique history. They have led to the development of more client-centred or user-friendly interventions that meet people where they are at, working alongside them in determining what they want to change in their behaviour and what their goals and priorities for change will be. Even the BC Ministry of Health has stated, "By placing the choice in the hands of the individual, there is acknowledgement that most addictive behaviours represent a problem in self-management that can be resolved by the individual" (2004). These client-centred approaches have the potential to improve the response to women with substance use problems; however, the emphasis on self-management does not address women's need for connection or needs for childcare or respite from mothering during treatment.

A major distinction in formal substance use/addiction services is between services/programs that take an abstinence approach to intervention and services/programs that take a harm reduction approach. The abstinence approach programs encourage complete abstinence from alcohol and other psychoactive drugs, and tend to be informed by the disease model of substance abuse and addiction. Programs that have moved towards using the social learning models of alcohol and drug use described above have harm reduction goals. Harm reduction is a public health philosophy/approach that gives highest priority to the reduction of potential harm from substance use and supports policies and practices that address risky behaviours without

requiring abstinence. Harm reduction goals include reducing the use of alcohol and drugs to lower the risk of severe consequences such as HIV and Hepatitis C infection from needle sharing, informing people about health consequences of their behaviour, and creating improvements in other areas of people's lives (please see section called Moving Towards Safety: Using a Harm Reduction Framework for more information).

Some addictions service providers are now grounded in a broad bio-psycho-social perspective (others widen this further to include spiritual aspects). This broad framework takes into account the ways that various dimensions of life contribute to substance use and are affected by substance use (www.heretohelp.bc.ca).

Although there has been a general move away from the moral model of addiction and substance use within the treatment system, people with addictions continue to be stigmatised within society as being of low moral character and weak-willed. Largely because of this stigma, most individuals with alcohol or drug problems do not go for help, support or treatment due to a reluctance to disclose use (Centre for Addiction and Mental Health 2002). Feelings of self-blame, shame and guilt are especially common among women

5.2.7 A Gendered Critique Of Mainstream Substance Use/Addictions Policy And Service Provision

Similarly to mental health services, substance use services have been very poor at taking gender into account in understanding causes and developing treatments. Prior to the 1970s there was virtually no research on women with substance use problems and almost no gender specific treatment programming. Since then there has been a steady increase in both the quality and quantity of research on women's substance use and a growth in specialized women's programming (Poole 1997). However, women continue to be underserved in both prevention and treatment programs and information about women's needs remains scarce in many areas.

There are still very few programs that are accessible and appropriate for women, especially for mothers, pregnant women, Aboriginal women, women with disabilities, lesbians, women offenders and women with co-occurring mental health or trauma issues. Many rural, northern and Aboriginal women, for example, need to leave their communities to receive care and treatment. In terms of access to treatment services there are many barriers for women, including lack of knowledge about services, and fears of confidentiality breaches, child apprehension, coercive treatment and blame or judgement. It is widely agreed that there is an urgent need for woman-specific prevention, harm reduction and treatment approaches (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

Some examples of comprehensive woman-centred care have recently begun to emerge and these ideas are now successfully guiding some community-based and acute care policy and programming for women with substance use problems (see Poole 2003; Burgelhaus and Stokl 2005). The last few decades have seen the development of specialized day treatment programming for women, for example, which takes a holistic health approach and addresses barriers to access such as child minding and transportation costs (Day/Evening/Weekend Programming for Women or DEWW). The Aurora Centre at BC Women's Hospital is another example of woman-centred care, a provincial treatment setting that provides residential and day treatment, and support for early intervention with women to prevent FASD and other alcohol and drug related developmental disabilities. Fir Square is an 11-bed unit comprehensive prenatal and postpartum program that meets the needs of women with problematic substance use. Through liaison activities with community groups, and using a harm reduction approach, the program provides consolidated support for pregnant women, including addictions support. Evaluations of these woman-centred programs, and others like them, indicate substantial benefits for women that use them, ranging from increased engagement in treatment to a wide range of health improvements for women and their children (Poole 2000).

Gender, race and culture, age and other social determinants need to be better researched, prioritised and taken into account when designing and delivering substance use services, so that gender and culturally sensitive services are the norm rather than the rare exception.

5.2.8 Main Contribution Of The Substance Use/Addictions Sector

The main contribution of the substance use sector, in BC at least, is a change in paradigm from abstinence focused, confrontational interventions to client-centred, harm reduction approaches. While this is not present everywhere, and can still be very vulnerable to policy changes, it is a driving force for change; indeed, BC has a reputation for being a world leader in harm reduction in relation to drug treatment. The strong history and presence of the self-help sector is also a contribution of this sector.

There is also an emerging holistic model in the substance use field that has the potential to build on the merits of motivational, educational and cognitive-behavioural approaches, evidence-based pharmacotherapy, public health informed harm reduction, by adding other holistic/integrative techniques such as acupuncture, meditation and stress management (BC Ministry of Health 2004).

5.2.9 Current Configurations Of Substance Use/Addictions Service Delivery

Like mental health services, most addictions services are now funded by provincial governments and delivered through regional health authorities for the population at large, and by the federal government for on-reserve Aboriginal people, members of the armed forces and those in the federal corrections system. Also, again with similarities to mental health, services are not only provided by specialized programs but also delivered in hospitals (chemical dependency resource teams) or through outpatient or home-based arrangements.

Recent reform of substance use/addiction services has placed a high priority on early identification and intervention and on the development of a wide range of community-based services that sit along a continuum of care that includes withdrawal management, comprehensive assessment, brief intervention, more intensive outpatient or day treatment, short or longer term residential treatment and continuing care.

A "stepped care" approach has been developed that staggers support, care and treatment depending on the client's needs, usually starting with the least intrusive level of care and then stepping up or stepping down, depending on the results from ongoing outcome monitoring. Those who are referred to specialized services have more serious problems. Counselling is provided in many arenas, such as schools, workplaces, community-based social services and corrections agencies as well as the more traditional substance use treatment services. Family physicians may also provide counselling and prescribe drugs to treat drug and alcohol problems, especially in rural areas where there may be few specialized alternatives (Centre for Addiction and Mental Health 2002). Women and their advocates have complained of the shortage of family physicians and services for women across BC, particularly outside the urban areas.

In general, treatment provided by specialised services tends to be non-medical in approach and referrals are made to outside medical and psychiatric services if needed. Self-help groups continue to play an important role in local treatment systems; indeed, far more people attend these groups than seek help from specialized treatment programs (Centre for Addiction and Mental Health 2002). These groups are self-supporting, organized by people recovering from a substance use problem themselves, and tend to have a disease model perspective advocating complete abstinence for their members/attendees.

For more information on specific treatments for substance use problems, please see the section Treatment Issues with Mental Health and Substance Use Problems.

5.2.10 References, Resources And Further Reading

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