

Building *Bridges*

Linking Woman Abuse, Substance Use and Mental Ill Health

Summary Report, January 2008

prepared by Louise Godard, Jill Cory and Alexxa Abi-Jaoudé



Building Bridges

Linking Woman Abuse, Substance Use and Mental Ill Health



TABLE OF CONTENTS

INTRODUCTION	03
BACKGROUND: MAKING THE LINKS	04
OVERVIEW: BUILDING BRIDGES	05
BUILDING BRIDGES: TERMS OF REFERENCE	07
STATEMENT OF THE ISSUE	07
VISION	07
GOALS	08
OBJECTIVES	08
KEY FINDINGS: BUILDING BRIDGES CONSULTATION	09
FIRST, DO NO HARM	09
KEY SYSTEMIC BARRIERS	10
WOMEN-CENTRED FRAMEWORK: PART OF THE SOLUTION	11
A WORD ABOUT TRAUMA	12
A CAUTION ABOUT SCREENING FOR WOMAN ABUSE	13
KEY RECOMMENDATIONS	13
OVERARCHING RECOMMENDATIONS	13
CONSULTATION	14
GUIDELINES	14
COLLABORATION	14
TRAINING AND INFORMATION	15
INTEGRATED SERVICES	15
POLICY	15
LEADERSHIP AND FRONT-LINE COMMITMENT	15
REFERENCES	16
FOR MORE INFORMATION	16



“UNDERSTANDING THAT VIOLENCE AGAINST WOMEN IS PERVASIVE AND CENTRAL TO THE DEVELOPMENT OF ADDICTION AND MENTAL HEALTH ISSUES PROVIDES US WITH A FOUNDATION TO MOVE TOWARD IMPROVED, SAFE AND RELEVANT SERVICE PROVISION FOR WOMEN.” - FINKLESTEIN¹

INTRODUCTION: BUILDING BRIDGES

Research, practice and women’s narratives all confirm that the link between woman abuse, substance use and mental ill health is a pressing, multi-faceted women’s health issue. These inter-connected issues are challenging women’s organizations and health services to respond in a meaningful way to women impacted by abuse,^{*} particularly those women whose experiences are compounded by substance use and/or mental ill health. Recognizing these complexities, the Provincial Woman Abuse Response Program at BC Women’s Hospital and Health Centre identified the need to engage in province-wide discussions, consultations and educational forums with community and health partners to further our knowledge and develop a provincial strategy. These partners consistently report the difficulty of supporting women with complex life circumstances and highlight the critical need for direction and action to improve services that support women’s safety and health. With strong partnerships

across the anti-violence and health sectors, and informed by the emerging research, the Woman Abuse Response Program launched the initiative ‘Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health.’ The goal of this provincial initiative is to encourage and foster cross-sectoral dialogue within and across the mental health, addictions and anti-violence sectors, and ultimately, to develop a provincial framework to guide the future direction of services, policy and research in British Columbia.

^{*} Throughout this document, the term abuse encompasses the many forms of abuse and violence that women experience including, but not restricted to, emotional, physical, verbal, sexual, psychological, financial, spiritual and cultural. It refers to both current and historic experiences of abuse and violence and includes both girls and women.



“WHAT APPEARS TO BE A CONSTELLATION OF SYMPTOMS OR DISORDERS MAY REFLECT A NORMAL RESPONSE TO TRAUMA AND THE SOCIAL REALITIES OF CONTINUED ISOLATION AND DANGER.” - WARSHAW²

BACKGROUND: MAKING THE LINKS

Gender-based violence is pervasive in the lives of girls and women around the globe. Recent reports from the World Health Organization indicate that 29%-62% of ever-partnered women have experienced physical and/or sexual violence in their relationships.³ The magnitude of these numbers is apparent when we consider that these statistics do not include abuse that occurs outside of relationships. Violence against women in relationships is viewed as one facet of a global picture of gender oppression that includes rape and sexual coercion, forced sexual initiation, sexual abuse of girls, trafficking, forced prostitution, exploitation of labour, debt bondage, violence against prostitutes, rape in war, sex-selective abortion, female infanticide, deliberate neglect of girls, and female genital mutilation.⁴

The impacts of abuse are extensive and varied, affecting many aspects of women's lives including their physical, emotional and mental health. As well, social circumstances such as unsafe and inadequate housing and low income levels can increase women's vulnerability and marginalization. Racism and other forms of oppression add another layer of complexity and risk to women's

experiences of abuse, compounding the experiences of victimization and retraumatization.¹¹

The body of empirical knowledge about the prevalence of gender-based violence and the devastating impacts of traumatic life experiences on women with mental ill health and/or substance use issues continues to grow. Research shows that:

- » Women in community samples report a lifetime history of physical and sexual abuse ranging from 36 – 51% while women with substance use issues report a lifetime history of abuse ranging from 55 – 99%⁵
- » As many as two-third's of women with substance use issues have a concurrent mental health problem (e.g., PTSD, anxiety, depression)⁶
- » 50% of women in psychiatric settings have been sexually abused as children⁷
- » Prevalence rates of depression among women with experiences of abuse are 38 – 83% compared to the general population of women rated at 10%⁸

During the consultation processes to date, service providers have identified with the findings of research, observing that they are



“I DON’T CALL IT MENTAL HEALTH, I CALL IT SYMPTOMS OF ABUSE, BECAUSE TO ME THAT IS WHAT IT IS.”

- GAIL, WOMAN ABUSE SURVIVOR⁹

seeing an increasing number of women living with compounding and intersecting issues of abuse, substance use and/or mental ill health issues. They also emphasize that women are not a homogenous group, and as such our response to women must be as diverse as their lives.

OVERVIEW: BUILDING BRIDGES

Recognizing the need to develop an improved response for women living with the overlapping experiences of woman abuse, substance use and/or mental ill health, many organizations are exploring ways to respond to this reality. However, many have identified gaps within current service models and barriers to increasing accessibility, particularly for the most vulnerable and marginalized women seeking safety and support. ‘Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health’ supports this change process. Change of this magnitude requires cross sector engagement, thinking, networking and action, which are the cornerstones of Building Bridges.

The Woman Abuse Response team set out to ask, “How can we use a cross-sectoral approach to inform changes in practice and service

models?” In an initial forum held at BC Women’s Hospital and Health Centre in Vancouver on December 14 & 15, 2006. More than 50 service providers, researchers and decision-makers, primarily from anti-violence organizations, around BC were invited to:

- » Explore the complexities and links between woman abuse, substance use and mental ill health;
- » Explore how these issues impact service delivery and practice;
- » Identify the gaps in service provision; and
- » Identify and problem-solve ways to reduce access and service delivery barriers.

Based on the dialogue and results of the December 2006 forum, the Woman Abuse Response Program made a commitment to continue the consultation process across BC and across sectors. The participants who attended the forum also identified the need to expand the scope of leadership beyond the Woman Abuse Response Program, leading to the formation of the Building Bridges Steering Committee, currently with 15 representatives from across BC. The Steering Committee, supported by the Woman Abuse Response Program, has facilitated a number of workshops and forums with the aim of sharing current research about the intersection of the issues; fostering intra- and



cross-sector dialogue; gathering information and perspectives; and identifying challenges, strategies and recommendations for improved service delivery throughout BC. During 2007, over 900 professionals have participated in Building Bridges initiatives, reflecting the interest of providers across the province to improve services for women. The following are some examples of Building Bridges consultation and education forums:

- » Interior Violence and Women's Health Network. This Network meeting resulted in community action plans being developed for 14 communities in the Interior Health Authority to improve services for women impacted by abuse, substance use and mental ill health at the local level. Kelowna - 85 participants.
- » UK and USA Videoconference Expert Panel and Community Consultation. Leading experts presented their experiences and evaluation of developing integrated service models followed by an afternoon of dialogue, gap analysis, service consensus statements and recommendations. Vancouver – 230 participants (100 participants on-site, 16 provincial sites - 130 participants across BC linked in via videoconference and led by 6 panel experts).
- » BC/Yukon Society of Transition Houses (BCYSTH) key note panel address. Vancouver – 350 participants
- » BCYSTH Building Bridges Workshop, information sharing, service consensus statements and recommendations for transition houses. Vancouver – 25 participants
- » BC Women's Hospital and Health Centre, environmental scan and formation of in-house steering committee to develop collaboration between programs. Vancouver - 20 interviews (14 women's health programs)
- » Provincial Women's Health Network, Northern Health Authority. Information sharing, development of service consensus statements and recommendations for Northern Health response. Prince George – 70 participants
- » BC Association of Specialized Victim Assistance and Counselling Program, Building Bridges Workshop, gap analysis, action plans and recommendations. Vancouver – 25 participants
- » Vancouver Island Health Authority, Building Bridges Workshop. Nanaimo – 100 participants
- » Building Bridges Advocacy and Action Toolkit to assist communities and regions to develop and implement strategic service approaches to improve services for women experiencing abuse with compounding substance use and mental health impacts.



BUILDING BRIDGES: TERMS OF REFERENCE

Based on the consultation and information sharing processes described above, Building Bridges has developed the following provincial mandate:

STATEMENT OF THE ISSUE

Women report that they feel silenced and disempowered when their experiences of abuse and other forms of oppression are ignored or minimized. Service providers across the sectors share concerns that services, responses and treatment approaches for women can be irrelevant or dangerous if their experiences of abuse and other harmful life factors are ignored when providing substance use and mental ill health treatment. When women's substance use and mental ill health are not identified as rooted in gender-based violence their experiences are often compartmentalized, their safety may be compromised through inappropriate treatment, and the impacts of abuse may be misdiagnosed as mental health or addiction problems in isolation from her unsafe life context. Similarly, if substance use and mental health issues are not acknowledged as impacts of abuse, women seeking safety and support from anti-violence services may not receive appropriate services.

VISION

There is now very strong evidence that woman abuse usually *precedes* substance use and mental health issues.¹ At the same time, women with mental ill health or substance use issues are more vulnerable to abuse.¹⁰ Yet, these links tend to go unrecognized by service providers, researchers and policy makers. Building Bridges participants envision that improving service delivery by making these connections will lead to the following key outcomes:

- » **Service models will reflect women's realities.** This will result in service providers being better equipped to work with women and enhance their capacity and ability to support women. This also has the potential to reduce frustration and burnout among service providers.
- » **Increased collaboration, coordination and partnerships.** Despite the challenges and differences, there are many similarities across the sectors that can provide opportunities for cross-sectoral work. This approach will increase appropriate service provision and effectiveness and reduce risks for women.
- » **Integrated services and service delivery.** Service providers will be able to name the links from first point of contact with a client. The improved capacity and ability of services across the sectors to respond to the intersecting issues will benefit women as well as potentially legitimize the work of all three sectors.



» **Knowledge will inform educational programs.** Knowledge includes those experiences and narratives provided by women and the front-line workers who support women. This will better prepare workers entering the field and enhance service provider's ability to effectively support women's needs.

GOALS

The goals of Building Bridges are to:

- » Understand the ways woman abuse, substance use and mental ill health impact women's lives;
- » Understand what services can do to respond and effectively address the reality of women's lives;
- » Increase safe choices for all women, particularly those who are living with overlapping experiences of woman abuse, mental ill health and/or substance use, by reducing gaps in service provision and working towards a more integrated response;
- » Raise awareness and standards of practice within the woman abuse, mental health and substance use sectors across BC; and
- » Develop a provincial framework to guide services, policy and research in improving the response to women impacted by abuse, substance use and/or mental ill health.

OBJECTIVES

The objectives of Building Bridges are to:

- » Identify gaps in service provision, level of need, and promising practices within all three sectors;
- » Use the findings to develop best practice guidelines for each of the sectors as well as integrated models;
- » Increase the capacity of services to effectively and safely respond to women's needs;
- » Increase the number of no or low barrier services;
- » Educate service providers;
- » Develop more effective responses across the separate sectors; and
- » Encourage networking, collaboration and partnerships among the woman abuse, mental health and substance use sectors



KEY FINDINGS: BUILDING BRIDGES CONSULTATION

Through on-going province-wide, sector-specific and cross-sector forums, Building Bridges engages service providers in education, consultation and strategic planning. Participants also analyze the current context of services, practices and policies and reach consensus about key issues that interfere with achieving safety and improved services for women. These findings are reported below.

FIRST, DO NO HARM

“[WHEN I DESCRIBED THE HEALTH IMPACTS OF THE ABUSE] MY DOCTOR SAID “NOTHING IS WRONG WITH YOU. JUST RELAX. GO ON A VACATION.”

– WOMAN ABUSE SURVIVOR¹¹

Evidence tells us that a lack of an integrated and coordinated approach increases women’s risk of further harm. Providers and the women they support have expressed fears that this vulnerable population of women is ironically more often excluded from service provision, putting them at even greater risk. Building Bridges participants report that limited mandates, inadequately trained staff, and providers’ fears about supporting women who are experiencing abuse, mentally ill, or substance using result in high barrier services.

Quotes from practitioners demonstrate how limited service mandates and staff knowledge about women’s needs results in access issues for women.

“WE HAVE A ZERO-TOLERANCE POLICY IN OUR TRANSITION HOUSE FOR WOMEN EXPERIENCING ABUSE. HOW MANY WOMEN EXPERIENCING ABUSE USE SUBSTANCES TO COPE? IT’S CRAZY TO TURN THEM AWAY.”

– ANTI-VIOLENCE WORKER

“IF I’M WORKING WITH A WOMAN WHO’S ABUSED, I TELL HER THAT WE NEED TO WORK ON HER ADDICTION FIRST. THERE’S NO WAY SHE CAN ADDRESS HER RELATIONSHIP PROBLEMS UNLESS SHE DEALS WITH HER UNDERLYING SUBSTANCE USE PROBLEMS.” - ADDICTIONS COUNSELLOR

In addition to the less than adequate number of accessible services for women, the current mode of delivering health care is in fragmented ‘silos’. Anti-violence, mental health and substance use services have historically been separate services, resulting in compartmentalized care that compromises women’s safety. Even when the range of a woman’s needs is recognized, service mandates can prevent a holistic approach, leaving her feeling fragmented and without any continuity of care. The important need for cross-sectoral collaboration and partnerships is evident when considering all of the evidence and acknowledging that service providers may not feel adequately equipped to support women with compounded and intersecting issues.



KEY SYSTEMIC BARRIERS

Despite the evidence about the links between woman abuse, substance use and mental ill health, participants report that current service provision and service models do not necessarily reflect women's realities. To achieve the desired goals and objectives of integrating and improving services, evidence and findings derived from the consultation process clearly point to the need to reduce systemic barriers and achieve no- or low- barrier services. This will take leadership, resources, time and effort, including a strong commitment from all three sectors.

Building Bridges participants consistently identify a number of key systemic barriers which currently have an impact on women trying to access services and providers' capacity to respond effectively. These include:

- 1.** Lack of knowledge and understanding across all sectors about the links between experiences of woman abuse, substance use and mental ill health;
- 2.** Philosophic, mandate and model of practice differences across sectors;
- 3.** Funding and resource inequities between government and non-profit services;
- 4.** Fragmented or single issue services;
- 5.** Reliance on stereotypes of women impacted by abuse, substance use and/or mental ill health that negatively influence appropriate, supportive responses;
- 6.** Lack of women-centred and gender specific options for women;
- 7.** Lack of policies developed with a gender perspective and/or analysis of the impacts of abuse on women's lives; and
- 8.** Complexity of meeting the needs and maintaining safety of all women and their children accessing services.

In addition to the daunting list of barriers that women and service providers face in providing services and support to women, Building Bridges participants have identified the need for a Women-Centred Approach as the fundamental guide for designing and delivering services.



WOMEN-CENTRED FRAMEWORK: PART OF THE SOLUTION

A women-centred framework¹² is required to improve services for women impacted by abuse, decrease further risks and avoid retraumatization. A women-centred approach starts from women's experiences, understanding that the social context of oppression and discrimination are primary contributors to women's lack of safety. Integrating evidence about the links between woman abuse, substance use and mental ill health into all aspects of service delivery is also fundamental to ensuring that services are women-centred.

Employing women-centred processes such as cross-sectoral dialogue and collaboration, partnership initiatives and knowledge sharing will support all sectors to share their expertise and reduce the potential for harm when service providers are interacting with women.

Studies echo what Building Bridges participants have identified as necessary for improving services for women: outcomes for women are more likely to be positive if their situation is approached in a women-

specific, integrated and holistic way, recognizing the likelihood of a history or current context of abuse. Conversely, when the impacts of abuse, including trauma, are not recognized, or if women's safety is minimized or discounted, attempts to address addiction or mental health issues are unlikely to be effective. In fact, not recognizing these issues can increase risks to women. By directly addressing the impacts of abuse; understanding that substance use and mental health concerns are linked to abusive experiences; helping women identify their experiences as abuse; and placing responsibility on the abuser, women will have greater access to safety and healing.

Additional women-centred principles include:

- » placing women's needs and preferences at the centre of care-giving models;
- » recognizing the prevalence of violence in the lives of girls and women;
- » integrating the social determinants of health into care;
- » acknowledging and responding to diversity among women;
- » ensuring women's participation in care; and
- » respecting women's strengths.

“WE OFTEN KNOW WHAT WE NEED, AND WE OFTEN KNOW WHAT’S WRONG. [IT WOULD BE GOOD] IF THERE WAS SOME WAY FOR US TO BE MORE INVOLVED IN THAT PROCESS AND HAVE MORE OPTIONS [AND] BE SUPPORTED [IN EXERCISING THEM].” WOMAN ABUSE SURVIVOR¹¹



A WORD ABOUT TRAUMA

The recent trend among health care providers and community advocates to replace descriptions of woman abuse with the language of trauma requires careful consideration. Using 'trauma' to describe violence against women raises concerns that key social and political analyses of violence against women will be eroded and that it conceals the gendered nature of abuse. Trauma labels have historically been associated with mainstream mental health diagnostic and treatment approaches, often devoid of a gender-based analysis. Without a backdrop of women's inequality as an analytic framework, which is often absent in mental health and addictions practice models, essential aspects of women's safety can be ignored or minimized.

By focusing on violence against women within a socio-political context, inequalities associated with being female remain central to understanding violence and its impacts on women. When trauma is conceived of as an individual experience devoid of an intentional perpetrator or hostile social circumstances, solutions may be adopted that are focused on individual change, coping strategies and personal responsibility, rather than solutions aimed at women's

safety and social, legal and human rights reforms. Relying on traditional perspectives about women's lives can unintentionally blame women for their circumstances and recommend solutions that place women at even greater risk while ignoring the fact that women's safety is compromised or threatened by her perpetrator or by social circumstances over which she has little or no control.

More recently, the language of trauma has also been adopted by some in the anti-violence sector to describe women's current and historic experiences of gender-based violence. This shift has led some to question whether using 'trauma' is an attempt to legitimize violence against women as a mainstream problem. It is worrisome that the historic commitment and focus on women's safety and equality embodied in the anti-violence sector may be weakened by this shift. In moving forward, it is essential that a women-centred approach frame all recommendations, service improvements, education, policy and research when making the connections between woman abuse, substance use and mental ill health. From this perspective, trauma, particularly complex post-traumatic stress, will be recognized as one of many impacts of violence against women.



A CAUTION ABOUT SCREENING FOR WOMAN ABUSE

One response from the health sector has been to consider universal screening for woman abuse. The intent of screening is to identify women experiencing abuse. This approach is debated because of the lack of evidence that shows screening increases women's safety within health care settings or in their relationships. In fact, a review of the screening literature suggests that screening does not increase the identification of abused women, nor does it lead to positive interventions or outcomes. It has been argued that screening does not even meet the basic criterion of 'do no harm'.^{13,14} Therefore, based on evidence, feedback from women themselves, health care providers and women's advocates, implementing any approach designed to identify women experiencing abuse is not recommended. Because of the high correlation between mental ill health, substance use and woman abuse, when any these 'conditions' are present for a woman, it would be safest to proceed as if historical or current abuse was a central aspect of her experiences. This can be done without requiring a woman to disclose experiences of abuse.

KEY RECOMMENDATIONS

The following is a summary of recommendations that have been proposed by Building Bridges participants. Participants and the evidence highlight that cross-sectoral work and service integration does not cost more than current modes of service delivery, rather services become more effective with a model of collaboration and integration.¹⁵

OVERARCHING RECOMMENDATIONS

- 1. Woman as expert** – The best outcomes for women result when women are seen as experts of their own experience and are involved in the development of the support they receive and their safety and treatment plans. Including women as informants for service development also contributes to services which are more reflective of women's realities and therefore more effective.
- 2. Holistic approach** – Recognize a woman as a whole person. Taking women's life contexts into consideration, which includes acknowledging the links between abuse, substance use and mental ill health, will decrease the likelihood that women will receive ineffective, unsafe and fragmented care.



3. Build on evidence – Looking to the research and successful models of integration will help bridge information gaps, and highlight opportunities for cross-sectoral collaboration and integration.

4. Reduce Barriers – Commit to reducing service barriers, including those outlined above, to ensure improved accessibility for women to low or no barrier services.

The following recommendations focus on strategic actions that are required to improve services that link woman abuse, substance use and mental ill health. This list is not exhaustive and continued dialogue among and between the anti-violence, substance use and mental health sectors will allow the ongoing development of recommendations and strategies for action.

CONSULTATION

- 1.** Consult with women, service users, service providers and stakeholders to make the links between woman abuse, substance use and mental ill health and identify what effective, relevant and improved service provision would look like within and across the sectors.
- 2.** Consult with women and service users in program and policy development.

GUIDELINES

- 1.** Develop best practice guidelines and service models for each sector.
- 2.** Develop a provincial framework for cross-sectoral collaboration and integration.

COLLABORATION

- 1.** Find opportunities for collaboration. Despite the challenges and differences, there are many possibilities for cross-sectoral work.
- 2.** Build relationships and partnerships within and across the sectors, supporting interagency relationships and collaboration.

TRAINING AND INFORMATION

- 1.** Educate all three sectors about the impacts of experiences of abuse and/or trauma, particularly in relation to substance use and mental ill health.
- 2.** Share information and provide cross-sectoral and joint training.
- 3.** Educate all sectors about the importance of the integration of women-centred care into the work of all sectors.



INTEGRATED SERVICES

- 1.** Develop more services that provide a wrap-around approach, where women can get all of their needs met with fewer barriers.
- 2.** Develop more women-specific and trauma informed services, particularly in the area of substance use and mental health.
- 3.** Work towards bridging cultural gaps within and across the sectors.

POLICY

- 1.** Mainstream gender-based policies.
- 2.** Ensure representation and inclusion of women and service users in program and policy development.
- 3.** Develop protocols with relevant ministries to support intra and cross sector work.
- 4.** Address wage status discrepancies between woman abuse, substance use and mental health sectors.
- 5.** Address different and conflicting philosophical approaches within the sectors.

LEADERSHIP AND FRONT-LINE COMMITMENT

- 1.** Secure leadership commitment to the Building Bridges process within all sectors.
- 2.** Secure front-line commitment to women-centred integrated processes and practices



REFERENCES

1. Finklestein, N., (1994). "Treatment Issues for Alcohol- and Drug-Dependent Pregnant and Parenting Women: in Health and Social Work, 19(1): 7-12.
2. Warshaw, C., Intimate partner abuse: developing a framework for change in medical education. *Academic Medicine*, 1997. 72 (Supplement): p. S26-S37
3. World Health Organization (2005). *Multi-country Study on Women's Health and Domestic Violence against Women*. Geneva: WHO Press.
4. Heise, L.L., et al., (1994). "Violence against women: a neglected public health issue in less developed countries." In *Social Science and Medicine*, 39(9): 1165-79.
5. Najavits LM, Weiss RD, Shaw SR (1997). "The link between substance abuse and posttraumatic stress disorder in women: A research review." In *American Journal on Addictions*, 6: 273-283.
6. Zilberman, et al. (2002). "Towards best practices in the treatment of women with addictive disorders" in *Addictive Disorders*, 1(2): 39-46.
7. Meuser KT, Bond GR, Drake RE & Resnick SG (1998). "Models of community care for severe mental illness: a review of research on case management." in *Schizophrenia Bulletin* 24 (1): 37-74.
8. Cascardi et al (1999). "Co-occurrence and Correlates of Posttraumatic Stress Disorder and Major Depression in Physically Abused Women." In *Journal of Family Violence* 14 (3): 227-249.
9. Humphreys, C. and Thiara, R. (2003) 'Domestic violence and mental health: 'I call it symptoms of abuse'; *British Journal of Social Work*, 33(2): 209-226.
10. Parks, K.A. and Miller, B.A. (1997). Bar Victimization of Women. *Psychology of Women Quarterly*, 21, 509-525.
11. Cory, J. and Dechief, L. (2007). SHE Framework: Safety and Health Enhancement for Women Experiencing Abuse. Available at: www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse
12. Cory, J. (2007). *Women-Centred Care: A curriculum for health care providers*. Vancouver Coastal Health Authority and BC Women's Hospital and Health Centre. Accessible at: <http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Resources.htm>
13. Ramsay, J., et al., Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal*, 2002. 325: p. 314- 26.
14. Garcia-Moreno, C., Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet*, 2002. 359: p.1509-14.
15. H. Clark, A. Power (2001). Women, Co-occurring Disorders, and Violence Study: A case for trauma-informed care. *Journal of Substance Abuse Treatment*, 28 (2): 145-146.

FOR MORE INFORMATION, CONTACT:

Jill Cory jcory@cw.bc.ca

Alexxa Abi-Jaoude aajaoude@cw.bc.ca

Louise Godard lgodard@cw.bc.ca

WOMAN ABUSE RESPONSE PROGRAM

BC WOMEN'S HOSPITAL AND HEALTH CENTRE

E408 4500 OAK STREET, VANCOUVER, BC V6H 3N1

604.875.3717

