COMBINED PROGRAMMING TO SUPPORT WOMEN-IDENTIFIED SURVIVORS OF DOMESTIC VIOLENCE EXPERIENCING CO-OCCURRING PROBLEMATIC SUBSTANCE USE

by

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Combined Programming to Support Women-Identified Survivors of Domestic Violence Experiencing Co-Occurring Problematic Substance Use

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Abstract

Women-identified survivors of domestic violence (DV) experiencing co-occurring problematic substance use (SU) have complex service needs which are inadequately addressed by traditional siloed approaches to service delivery. Combined programming, which simultaneously addresses needs related to both DV and SU, demonstrates effectiveness in addressing the needs of this population. However, research is only recently emerging, and agencies have been slow to incorporate combined interventions. Addressing this critical gap, this qualitative study explored the strengths and limitations of community-based agencies in Canada offering combined DV/SU programming. Using an Interpretive Description design, semi-structured interviews with service providers offering combined DV/SU programming were used to explore the specific motivations, theoretical approaches, policies, successes, and barriers to implementing such programming. The study found that successful programming was informed by trauma-informed, client-centered, and harm reduction approaches, and focused on addressing DV/SU needs holistically. The study also uniquely described the unanticipated impacts of the COVID-19 pandemic, including increases in complex client needs and limitations placed on community-based agencies, in motivating practice shifts towards combined interventions. Practice recommendations garnered through participant interviews included efforts to increase staff competencies, address stigma and misconceptions, build agency capacity, and further incorporate trauma-informed, client-centered, and harm reduction approaches. This study provides useful insights for future research, policies, and supports that would address the unique needs of women experiencing DV/SU.

Lay Summary

Domestic violence (DV) and problematic substance use (SU) are both major public health issues that have high rates of occurring together. While community-based agencies have historically offered services for DV and SU separately, some agencies have begun to implement combined programming that simultaneously addresses client needs related to both DV and problematic SU. The purpose of this study was to learn more about the practices, successes, and barriers of offering combined DV/SU programming to women-identified clients from the perspective of agency professionals. Findings showed that successful programming considered the impacts of trauma, prioritized promoting client safety, building authentic relationships with clients, and addressing client needs holistically. These findings provide insights for future research, policies, and supports that would address the unique needs of women experiencing DV and problematic SU.

Preface

This thesis is an original work written by Savanna Belitski. The relative contributions of all co-contributors and co-authors are listed here. Identification and design of the research conducted were developed by Savanna Belitski with guidance from Dr. John Graham. All components of this thesis, including the abstract, introduction, literature review, methods and design, findings, discussion, and conclusion, were written solely by Savanna Belitski with feedback from Dr. John Graham, Dr. Mary Clare Kennedy, and Dr. Victoria Burns. Savanna Belitski conducted all components of data collection, analyses, and syntheses under the supervision of the aforementioned individuals. Generative AI was not used in anyway to prepare this thesis.

Ethics approval was granted for this study by the University of British Columbia Okanagan Behavioural Research Ethics Board (UBC BREB Number: H 23-00741). To date, no findings of this thesis have been published or submitted for publication and no formal presentations on study findings have been presented.

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Glossary

Abstinence-Based Model

An approach to problematic substance use treatment which promotes total abstinence from substance use as the goal of treatment, and requires abstinence as a condition of program participation (O'Leary et al., 2022).

Community-Based Organizations

"nonprofit membership organizations (public or private) open to all residents of the physical community (a neighborhood for example), and focused on issues and concerns at the local level" (Aideyan, 2018, p. 872).

Client-Centered Care

A theoretical approach to social work practice that is guided by authenticity, acceptance, and empathy, promoting individual client values and needs as the key goals and facilitators of the change process (Rothery & Tutty, 2016).

Combined Programming

For the purpose of this thesis, "combined programming" refers to a single program or service that pays combined attention to the intersection of co-occurring domestic violence victimization and problematic substance use as a core element of service design and delivery (Fowler & Faulkner, 2011).

Domestic Violence

Domestic violence refers to "intentional, ongoing, and systematic abuse intended to exercise power and control over an intimate partner; it can take the form of physical violence, verbal

abuse, sexual violence, psychological abuse, isolation, intimidation, stalking, threats, or economic abuse, among other abusive tactics" (Phillips et al., 2021, p. 534).

Emergency Domestic Violence Shelters

Shelters, usually community-based, which provide short term accommodation and respite to individuals and families experiencing domestic violence. Service provision often includes childcare, outreach, education, and case management (Rempel et al., 2024).

Harm Reduction

Harm reduction is a value neutral approach to substance use that aims to promote client safety and reduce the negative consequences and potential harms of substance-use behaviour without requiring abstinence or treatment seeking (Hovey & Scott, 2019).

Problematic Substance Use

For the purpose of this thesis, "problematic substance use" refers to "a maladaptive pattern of substance use that results in significant impairment or distress in the individual's life" (Swaine, 2011, p. 2432).

Second Stage Domestic Violence Shelter

Long-term (6-24 month) transitional housing for individuals and families fleeing domestic violence. Different from emergency shelters, these programs are often structured as apartment type units with common areas and support staff on-site (Rempel et al., 2024).

Substance Use Coercion

Substance use coercion refers to using substances as a tactic of control and power in the context of domestic violence. Tactics can include "coercing or forcing a survivor to use substances or to use more than they want . . . deliberately sabotaging a survivor's recovery efforts or access to

treatment, and/or engaging substance use stigma to make a survivor think that no one will believe them, forcing a partner into withdrawal" (Heward-Belle et al., 2022, p. 53).

Trauma-Informed Practice

"Trauma-informed care is a delivery approach that can be applied across different types of care and services and focuses on acknowledging the widespread symptoms and impacts of trauma while emphasizing sensitivity, safety, empowerment and confidentiality, and actively avoiding re-traumatization" (Stone et al., 2023).

Acknowledgements

I would like to extend my greatest appreciation to my thesis supervisor, Dr. John Graham, who saw value in my research topic and provided me the opportunity to see it through to this end. Thank you for your constant support, encouragement, and guidance throughout this process. I am also deeply grateful for my committee members, Dr. Mary Clare Kennedy and Dr. Victoria Burns. Your continued support, patience, and commitment to my research were hugely impactful, and I am incredibly grateful to you both for offering your expertise and guidance.

I would also like to thank UBC librarian Arielle Lomnes for lending her support and extensive research knowledge, without which conducting my first full literature review would have been an insurmountable task.

To my research participants for their dedicated commitment to supporting survivors of domestic violence and who were willing to take the time to contribute to this project.

And lastly, to my parents for their unwavering belief in my ability to complete this project, to my friends and classmates at UBCO who became my family away from home, and to my partner, Nathan, who took on everything else so that my focus could be here.

To all survivors of domestic violence, including those I have had the honour of walking alongside.

Introduction

Both domestic violence (DV) and problematic substance use (SU) are major public health issues which have serious health, wellbeing, and safety implications for those impacted (Cohn & Najavits, 2014; Gezinski et al., 2021; Morrison et al., 2022; Rothman et al., 2018; Stone et al., 2021, 2023). Decades of research has evidenced a bi-directional relationship between DV and SU with both challenges increasing the likelihood of experiencing the other, as well as an increase in severity of both challenges when they occur concurrently (Fernandez-Montalvo et al., 2017; Gezinski et al., 2021; Gilbert et al., 2015; Hovey et al., 2020; Humphreys et al., 2021; Mason et al., 2017; Morrison et al., 2022; Motz et al., 2019; Myers et al., 2015; Rothman et al., 2018; Stone et al., 2021, 2023; Weaver et al., 2015). Despite extensive evidence for their co-occurrence, services to support either issue have historically been siloed, addressing a single service need while ignoring or excluding the other (Armstrong et al., 2019; Capezza et al., 2014; Humphreys et al., 2005; Macy & Goodbourn, 2012). This has unsurprisingly led to negative outcomes for survivors of DV experiencing problematic SU as client needs are ineffectively met (Hill et al., 2022; Phillips et al., 2021; Stone et al., 2021), often leading this population to fall through the cracks of services (Macy et al., 2013).

In recognizing these barriers, an emerging practice in the DV and SU sectors has been efforts towards combined interventions that simultaneously address both DV and problematic SU, with specific consideration for the ways the two challenges influence one another. Studies focused on such programming have been promising in demonstrating the effectiveness of combined interventions to reduce the barriers of historically siloed approaches and promote positive health and wellbeing outcomes for clients (Edwards et al.,

2022; Gilbert et al., 2015, 2023; Motz et al., 2019; Myers et al., 2015). Community-based agencies have been slow to move towards combined interventions (Bennett et al., 2016; Cohn & Najavits, 2014; Hovey et al., 2020) and are doing so in inconsistent ways (Rothman et al., 2018). Barriers to implementation including funding and capacity limitations (Cohn & Najavits, 2014; Hovey et al., 2020; Hovey & Scott, 2019; Morrison et al., 2022; Morton et al., 2015; Nnawulezi et al., 2018), stigma and misconceptions about either issue (Gezinski et al., 2021; Hovey et al., 2020; Hovey & Scott, 2019; Morrison et al., 2022; Morton et al., 2015; Stone et al., 2023), and differences in theoretical approaches to practice (Armstrong, 2022; Isobe et al., 2020; Mason & O'Rinn, 2014; Sutton et al., 2021) have limited the ability of community based agencies to shift service delivery towards effective combined programming.

Therefore, the purpose of the present study is to identify community-based agencies across Canada offering combined programming for DV and problematic SU to explore promising practices in this area and provide recommendations for future service delivery. The study specifically sought to qualitatively explore the current practices and experiences of community-based agencies across Canada from the perspectives of agency professionals. By establishing a more fulsome understanding of the specific motivations, theoretical approaches, policies, successes, and barriers to delivering combined programming to this population, this research aims to inform future program development in order strengthen the services available to women experiencing DV and problematic SU.

What was gained from this study was specific, readily applicable learnings and recommendations from agency professionals to inform effective service delivery in this area. This included an emphasis on trauma-informed, client-centered, and harm reduction

approaches to practice which are intentionally aligned at all levels of the agency. Outcomes of the study also emphasize the importance of addressing stigma and misconceptions about either issue, working collaboratively with clients, agency professionals, and external systems, and engaging in ongoing education and professional development to improve competencies. These outcomes are significant to practice in this area as they inform on tangible actions that agencies can take to effectively implement combined programming.

Locating the Researcher

The researcher is a Registered Social Worker and has been working in the gender-based violence field for the last 5 years. This work has included direct service delivery roles within emergency and second stage community-based DV agencies, and presently as a counsellor at a sexual assault centre. This research topic arose out of the researcher's professional experiences serving survivors of DV experiencing co-occurring problematic SU and recognizing the challenges that many community-based organizations face in adequately meeting the complex needs of this population. The researcher also witnessed efforts by these agencies to move towards combined programming and became curious about how other agencies across Canada are engaging in this work.

The researcher additionally acknowledges the limits and privileges of their perspective as a settler-colonial, white, cis, bisexual, able-bodied, neurotypical woman operating within a colonial institution. The researcher has made efforts, described within the following chapters, to be reflective of the impact of the researcher's positionality on study findings. Additionally, the researcher has taken steps to promote transparency and collaboration with study participants by describing the researcher's positionality at the onset of participant interviews. Acknowledged within the limitations section of the concluding

chapter of this thesis are acknowledgements of the ways that this research aligns with colonial systems and processes. The researcher acknowledges the limitations imposed by this alignment in reflecting and highlighting the unique experiences of Indigenous agencies and practitioners, as well as limitations in highlighting the unique service needs of Indigenous women experiencing co-occurring DV and problematic SU.

Practitioner Perspectives

The only study known to the researcher which employed qualitative interviews to explore practitioner experiences of combined DV/SU programming was focused on programming for perpetrators across multiple countries (Mootz et al., 2022). Addressing this gap in research, the present study explores in-depth the experiences and opinions of service providers offering combined DV/SU programming. The use of qualitative interviews with participants allowed the researcher to gain a fulsome, nuanced understanding of the successes, challenges, and efforts of professionals in this area which were beneficial in informing recommendations for future practice.

Canadian Context

Only a small portion of studies identified in the literature review focused on service delivery for clients experiencing co-occurring DV and problematic SU within a Canadian context, none of which specifically explored combined programming. Therefore, developing research knowledge about the unique practitioner experiences and contexts of combined DV/SU programming in Canada is important. Given the unique histories and differences across Canadian provinces in terms of social policy development and implementation (Boychuk, 1998), research knowledge in this area is especially important for developing practice recommendations that are relevant and applicable to practice within Canada.

Additionally, Canada, as well as the global population, has also had to respond to the unanticipated impacts of the COVID-19 pandemic. Research evidence has shown that the pandemic has both increased global rates of DV (Kourti et al., 2023) and SU (Roberts et al., 2021) and has impacted service delivery among DV agencies (Montesanti et al., 2022). In recognizing that the pandemic has significantly shifted community needs and placed unanticipated pressures on DV agencies across the country, research in this area is especially important as previous literature may no longer accurately reflect current programming. Given that little is known about combined DV/SU programming within a Canadian context, especially in the aftermath of the COVID-19 pandemic, outcomes of this study are particularly important and relevant for community-based organizations engaged in both DV and SU work.

Assumptions

In alignment with the Interpretive Description approach applied throughout this research, it is important that the researcher acknowledges their own expectations and preconceptions upon entering this research (Thorne, 2016). Existing research, as described in the literature review chapter, notes multiple barriers to effectively implementing combined programming to address co-occurring DV and problematic SU. Due to these barriers, there has been no uniform approach to addressing co-occurring DV and problematic SU. As such, in beginning this research, the researcher was tentatively anticipating that agencies across Canada would be implementing combined programming in different ways and to varying degrees of success. Additionally, factors that were expected to influence the success of adapting service delivery, based on existing research, included agency capacity, training, funding priorities, and historical mandates.

Intent

No existing research, to the researcher's knowledge, has qualitatively explored the current practices and experiences of community-based agencies in Canada in offering combined DV/SU programming from the perspectives of agency professionals. As such, the current study interviews professionals from agencies that have excellent reputations in offering combined DV/SU programming with the aim of exploring promising practices in providing such programming. The outcomes of this research, described in subsequent chapters, offers valuable insight into current service delivery in this area, as well as recommendations for future practice.

The second chapter of this thesis presents the literature reviews that were conducted by the researcher to inform and locate the present study within existing research. Through these literature reviews, an understanding about the limitations of siloed approaches, recent shifts in service delivery in this area, effectiveness of combined interventions, and barriers to the implementation of combined programming across service sectors was gained. This chapter also presents the practice, education, and research recommendations presented within past literature which helped inform the focus of the present study.

The third chapter describes the methodology employed for the present study, including theoretical frameworks and epistemological perspectives. This chapter outlines the specific recruitment and interview strategies, and research processes employed, including an explanation of how Interpretive Description was applied to the methodology of the present study. This chapter also describes the intentional steps taken by the researcher to ensure qualitative rigor throughout the study.

The fourth chapter presents findings from participant interviews. These findings describe in detail the specific motivations, theoretical approaches, policies, successes, and barriers of community-based agencies in delivering in combined programming. This chapter additionally describes the process of shifting services towards combined programming and provides recommendations towards effective programming and ideal service models.

The fifth and final chapter provides a discussion of the ways that the study findings align, diverge, and build upon previous literature described within the second chapter. This discussion particularly highlights the contributions of the present study, as well as presents the limitations and strengths of the research. The chapter concludes by exploring questions for future research and presenting readily applicable recommendations for social work practice in this area.

Literature Review

For this study, two literature reviews were conducted; a preliminary literature review conducted broadly to assess the existing research available and a more comprehensive structured narrative review that narrowed in on combined service delivery for DV and SU.

Preliminary Review

The preliminary literature review broadly explored existing research on available service delivery for clients seeking supports related to both DV victimization and problematic SU to help inform the scope of the research question. Information was sought from Google Scholar. Keywords used as search terms included ("Intimate partner violence" or "domestic violence" or "family violence") and ("addictions" or "substance") and ("treatment" or "service*" or "clinical" or therap*"). Date of publication limiters were set to 2000-2023 and language set to English. Searches produced a total of 1570 results.

Article title and abstracts were then reviewed for proximity to the research topic to determine which full texts would be reviewed. Inclusion criteria, in addition to search limitations, for full texts to be reviewed include:

1. Having a topic of focus on both DV and SU;
2. Having a focus on women-identified survivors;
3. Having a focus on clinical service delivery/programming for survivors, which may also include services for families

Once reviewed for this criteria, 39 articles were pulled for full review. Of the full texts, 11 were in closest proximity to the research question. These 11 articles were assessed for their research population, methods, findings, and themes. Additional articles were acquired through tracking references.

Preliminary Findings

The bi-directional relationship between DV and SU has been explored and evidenced by research for over four decades (Humphreys et al., 2005), with both challenges increasing the likelihood of experiencing the other (Armstrong et al., 2019; Bennett, 2007; Bennett & O'Brien, 2010; Capezza et al., 2014; Fowler & Faulkner, 2011; Hertz et al., 2005; Humphreys et al., 2005; Mason & O'Rinn, 2014). For instance, survivors of DV are five times more likely to experience problematic SU compared to women without histories of DV (Macy & Goodbourn, 2012), and women who experience SU challenges report lifetime prevalence of DV at 55-99%, significantly higher than the general population (Bennett, 2007). Experiencing either DV or SU not only increases the likelihood of experiencing the other, but also the severity of both challenges when DV and SU occur concurrently (Armstrong, 2017; Mason & O'Rinn, 2014). Given the complex, bi-directional relationship between DV and SU, research efforts, as presented below, have focused on how DV and SU sectors respond to either issue.

Services to support survivors of DV, as well as treatment centers to address problematic SU, are well established, though services have historically taken siloed approaches, focusing on a single service need with little attention to co-occurring challenges (Armstrong et al., 2019; Capezza et al., 2014; Humphreys et al., 2005; Macy & Goodbourn, 2012). This lack of attention to co-occurring needs continues to be common among community-based agencies (Armstrong, 2017; Armstrong et al., 2019). In their dissertation on current rates and characteristics of combined DV/SU programming in Chicago, Armstrong (2017) found that, while some large organizations house both DV and SU

programming, they tend to offer these programs separately, with little focus on the co-occurrence of DV and SU.

Building upon the findings of their dissertation, Armstrong et al. (2019) interviewed professionals from DV, SU, and other community agencies across the U.S. to quantify the ways and extent to which such agencies are addressing both concerns. Of the 204 agencies in the study, only 13 (6.3%) focus on combined programming for DV and SU, while 90 (44.1%) are broadly defined community agencies that house separate programming for both concerns without attention to addressing their co-occurrence. Thirteen (4.9%) of the programs are labeled as other. The study found that organizations rarely addressed both concerns at the time of their founding and that there is no consistent way that combined services are being offered. Of the remaining 14 (6.8%) SU and 74 (36.2%) DV agencies in the study, it was found that SU agencies primarily address DV by incorporating services internally while DV agencies primarily address SU through external referrals and collaborations across sectors.

Further highlighting inconsistencies among agencies in addressing co-occurring DV and problematic SU, a national survey in the U.S. found that only 38.4% of SU treatment facilities offer services for DV and that formal screening procedures for DV are also rare (Capezza et al., 2014). Of the treatment facilities in the study, those that offer gender-specific services and more staff training are more likely to incorporate DV services (Capezza et al., 2014). In their mixed methods study on practitioner understandings of trauma in treating DV and problematic SU, Armstrong (2022) found that few agencies offer combined services, and that addressing trauma, DV, and SU together is rare. Armstrong et al. (2019) further found that screening and providing referrals for DV is often the extent of supports offered for DV in treatment settings.

Given the severity of co-occurring DV and SU, it is expected that single-focused service designs would be limited in meeting client needs when both challenges are present. Armstrong's (2017) dissertation found that addressing only DV or only SU when both are present can lead to poorer program outcomes and completion rates. Two studies examining client experiences accessing services through a 2-year demonstration project on coordinated services both highlight that women experiencing co-occurring DV and SU who access only DV services have worse outcomes related to SU and relapse than women who also access SU services (Bennett, 2007; Bennett & O'Brien, 2010). A review of past literature on programming for co-occurring DV and SU further supports that siloed services are ineffective at addressing co-occurring challenges and that available combined services are lacking (Macy & Goodbourn, 2012).

Multiple studies, in noting historical and present limitations of siloed services, recommend addressing DV and SU needs simultaneously as a best practice (Armstrong, 2017, 2022; Armstrong et al., 2019; Bennett, 2007; Bennett & O'Brien, 2010; Macy & Goodbourn, 2012). In their meta-analysis of interventions available to women for SU and trauma, Fowler and Faulkner (2011) found that interventions with combined focus on problematic SU and trauma show high efficacy in reducing rates of problematic SU for women-identified survivors of DV. These effects are especially evident among women with current compared to historical DV, younger women, and women of colour. Interestingly, the study also found that when accessing trauma-informed SU interventions, survivors of recent DV experience a more significant reduction in problematic SU than other trauma survivors (Fowler & Faulkner, 2011).

Another study which quantitatively explores how focusing on trauma can act as a potential link between DV and SU sectors found that agencies that primarily focus on treating trauma are significantly more likely to address the co-occurrence of DV and problematic SU compared to agencies that primarily focus on treating either DV or SU (Armstrong, 2022). Findings from these two, as well as other studies (Bennett & O'Brien, 2010; Hertz et al., 2005; Mason & O'Rinn, 2014), support an argument for trauma-informed care as a potential bridge between DV and SU sectors. Studies have also recommended better cross-sector collaboration and integration of services (Humphreys et al., 2005; Macy & Goodbourn, 2012), as well as additional training for frontline staff on understanding and assessing co-occurring DV and problematic SU (Armstrong, 2022; Mason & O'Rinn, 2014).

Despite evidence for addressing DV and SU concurrently, numerous barriers have limited the ability of agencies to do so effectively. For one, the DV and SU sectors have evolved from different philosophical and theoretical understandings of either issue, making combining services a challenge (Armstrong, 2017, 2022; Mason & O'Rinn, 2014; Sutton et al., 2021). For example, while SU has primarily been conceptualized and treated from an individually focused medical model (Armstrong, 2022), services for DV have developed based on sociological (Armstrong, 2022), feminist (Sutton et al., 2021), and family system frameworks of understanding (Armstrong, 2017). In acknowledging differing theoretical frameworks as a barrier, Armstrong et al.'s (2019) article highlights a recent trend among Violence Against Women (VAW) shelters in the U.S. in expanding their agency mandates to meet increasingly complex client needs. Additionally, surveys on DV, SU, and mental health practitioner opinions on best practices to treat co-occurrence across the three sectors also found that service providers may have different priorities in treatment (i.e. immediate safety

and stability in DV shelters vs. long term outcomes in SU/mental health services) making program design a challenge (Hertz et al., 2005). Different funding sources, training models, and resources across the two sectors are additionally noted as barriers (Mason & O'Rinn, 2014).

Past literature also highlights a lack of consensus among professionals on how to best treat co-occurring DV and problematic SU. For instance, Hertz et al. (2005) found that differences in theoretical understandings of trauma influenced opinions on best practices among professionals from both sectors. In their scoping review of literature on DV, SU, and mental health practitioner ability to address co-occurring client needs, Mason and O'Rinn (2014) found that, although there was high practitioner awareness of co-occurrence, there was no consensus among professionals on what was needed to improve competencies and address barriers. Suggestions among professionals in this study include improving screening procedures, cross-sector collaboration, and emphasizing trauma-informed approaches, though recommendations are vague and lack specific, actionable steps. In their review of available research on best practices and recommendations for addressing DV and SU simultaneously, Macy and Goodbourn (2012) highlight controversy in opinions on specific service delivery issues including safety risks and opinions on concurrence of DV/SU treatment.

Comprehensive Review

A more comprehensive structured narrative literature review was conducted to gain an improved understanding of the current knowledge on combined service delivery for women-identified DV survivors experiencing co-occurring problematic SU. Information was sought from the field of social work, as well as related fields including social services, health, and psychology. The databases utilized to source articles for review included

PsycINFO (EBSCOhost), Social Services Abstracts (ProQuest), MEDLINE (EBSCOhost), and CINAHL (EBSCOhost). All of the databases were accessed through the UBC library. Keywords used as search terms included ("intimate partner violence" OR "domestic violence" OR "emotional abuse" OR "family violence" OR "spouse abuse" OR "spousal abuse" OR "physical abuse" OR "economic abuse") AND ("substance abuse" OR "substance use" OR alcoholi* OR addiction OR "drug abuse" OR "drug use" OR "drug misuse" OR "alcohol misuse" OR "alcohol use disorder" OR "opioid use") AND (treatment* OR service* OR program* OR intervention* OR therap*). Variations explored through thesauruses.

Limiters were set to include only peer-reviewed articles with the language set to English.

Based on preliminary findings that combined service delivery for DV and SU is relatively new, the date of publication for searches was set to 2012-2023. Keywords and limiters were determined with support from UBCO Librarian, Arielle Lomness.

Searches produced a total of 4,113 results. There were 2,148 duplicates automatically removed, leaving 1,965 for review. Upon initial title reviews, it became evident that searches produced a large number of international articles which did not align with the scope of the present study. On recommendation from the primary thesis supervisor, with the intention of excluding irrelevant international articles, an initial title review was conducted to scan for and exclude articles focused on countries that are not members of the Organisation for Economic Co-operation and Development (OECD, n.d.). From this first review, 411 additional articles were removed, leaving 1554 for further review.

Once reviewed for this criterion, 47 articles were pulled for full review. Of the full texts, 33 articles were in closest proximity to the research question. Of these 33 articles, one

was an opinion article (Moir et al., 2022) and one was a conceptual article (Heward-Belle et al., 2022) and were excluded from the literature review but retained for background information. An additional three articles (Armstrong et al., 2019; Capezza et al., 2014; Macy & Goodbourn, 2012) found in the comprehensive review overlapped with articles utilized in the preliminary review. The overlapping articles were explored more in depth but were not included in the second literature review to avoid over representation of the perspectives of duplicated articles. The 28 remaining articles were assessed for their research populations, methods, findings, and recommendations. Additional articles were acquired through tracking references.

Study Approaches

The studies included in the comprehensive review consist of fifteen qualitative studies, eight quantitative studies, and five mixed methods studies. Six of the studies focus primarily on DV settings, practitioners, or clients with interest in co-occurring SU, and seven of the studies focus primarily on SU agencies, practitioners, or clients with interest in co-occurring DV. Ten of the studies focus equally on DV and SU, exploring either general help seeking experiences or combined interventions. The remaining five articles focus on other health or social service settings including healthcare and services for pregnant/postpartum clients, with attention to treating co-occurring DV and problematic SU. Twenty of the articles are from the U.S., four from Canada, and one article each from Australia, Ireland, New Zealand, and Spain.

Need for Combined DV/SU Services

Building upon research evidence from the preliminary review, this section describes the need for comprehensive combined interventions for co-occurring DV and problematic SU

by further describing the bi-directional relationship between DV and SU, as well as describing the ineffectiveness of previously siloed interventions in treating their co-occurrence.

Interconnection of DV & SU

Both DV and SU are cited as major public health issues (Cohn & Najavits, 2014; Gezinski et al., 2021; Morrison et al., 2022; Rothman et al., 2018; Stone et al., 2021, 2023), with DV impacting up to 25% of women in the U.S. (Macy et al., 2013) and 30% of women globally (Mason et al., 2017). Experiences of DV are associated with poor mental health outcomes including increased rates of post-traumatic stress disorder (PTSD), anxiety, and depression (Morrison et al., 2022). Physical health challenges including injuries, chronic health conditions, gastrointestinal issues, and reproductive health challenges (Morrison et al., 2022) are also cited. Similarly, three studies in the comprehensive review which focus on programming for problematic SU cite concerns related to the growing toxic drug crisis in the U.S., specifically a growing increase in rates of death involving unregulated drugs including illegally-manufactured fentanyl (Rothman et al., 2018; Stone et al., 2021, 2023). In addition to heightened death rates, problematic SU is also associated with physical and mental health problems, as well as contributing to isolation from needed supports (Hovey et al., 2020).

While both DV and SU are associated with adverse health outcomes, studies in the comprehensive review consistently evidence a bi-directional relationship between DV victimization and problematic SU, with both concerns increasing the risk and severity of experiencing the other (Fernandez-Montalvo et al., 2017; Gezinski et al., 2021; Gilbert et al., 2015; Hovey et al., 2020; Humphreys et al., 2021; Mason et al., 2017; Morrison et al., 2022; Motz et al., 2019; Myers et al., 2015; Rothman et al., 2018; Stone et al., 2021, 2023; Weaver

et al., 2015). Research has found that 7-50% of all DV survivors report co-occurring substance use disorder (Stone et al., 2023) and 67-80% of women in SU treatment report histories of DV (Bennett et al., 2016). Studies have also found that the physical and mental health challenges associated with DV are further complicated and exacerbated when co-occurring problematic SU is present (Weaver et al., 2015).

While SU may be a way for survivors to cope with abuse (Edmond et al., 2014, Macy 2013), literature also notes SU coercion as a prominent abuse tactic (Gilbert et al., 2023; Hill et al., 2022; Macy et al., 2013; Phillips et al., 2021). Tactics of SU coercion may include preventing survivors from accessing SU services, introducing and providing substances to keep survivors in vulnerable positions (Gilbert et al., 2023; Hill et al., 2022), using SU as a justification for violence, coercion of sex in exchange for substances (Macy et al., 2013), and threatening child apprehension due to the survivor's SU (Phillips et al., 2021). Studies interviewing DV survivors on their experiences of co-occurring problematic SU and help seeking have found both that SU may be introduced by an abusive partner as an abuse tactic or, in other cases, is a behaviour that precedes the initiation of the abusive relationship, highlighting the bi-directional nature of the two challenges (Hovey & Scott, 2019; Macy et al., 2013). Given the high rates and severity of co-occurring DV and problematic SU, it is especially important that programming and research efforts are focused on addressing their co-occurrence.

Inability of Siloed Services to Meet Co-Occurring Needs

Despite consistent evidence that DV and problematic SU are inter-related challenges, available services have historically been siloed, focusing on either DV or SU needs without consideration for the other issue (Hill et al., 2022). This, unsurprisingly, has led to an

inability of presently available siloed services to meet the needs of clients with co-occurring DV/SU needs. One qualitative study interviewing pregnant/postpartum survivors of DV with co-occurring opioid use disorder (OUD) on their experiences of service delivery found that participants perceived a lack of understanding about DV among SU professionals, negatively impacting their ability to access services (Hill et al., 2022). Participants specifically note concerns related to feeling judged or blamed by service providers for their DV experiences and DV screening questions that are abrupt and do not foster a sense of safety to encourage honest disclosures. Another qualitative study, which interviews women survivors of DV with co-occurring problematic SU found that women with co-occurring challenges often have complex service needs which are ineffectively met in siloed DV or SU programming, leading many women to fall through the cracks of services (Macy et al., 2013).

A more recent study interviewing the same population on experienced barriers to accessing DV and SU services had similar findings, noting lack of capacity in siloed programming and internalized stigma among clients in disclosing co-occurring challenges as barriers (Phillips et al., 2021). An additional study exploring help seeking among the same population in a rural community in Vermont found that internalized stigma, geographical isolation, and limitations of siloed programming are significant barriers to services (Stone et al., 2021). Three of these four studies also cite the abusers' use of SU coercion as an additional barrier to services, further highlighting the need for programming to address both DV and SU needs (Hill et al., 2022; Phillips et al., 2021; Stone et al., 2021).

One study examining SU treatment outcomes for a sample of women with and without histories of DV additionally found that 74.4% of the sample had a history of DV and that such history correlates with increased severity of SU and increased likelihood of

treatment dropout (Fernandez-Montalvo et al., 2017). These results further evidence the high rate of co-occurrence between DV and problematic SU, as well as the inability of traditional SU treatment models to address complexity. Further, a meta-analysis on the intersection of DV and problematic SU also found that lack of screening and attention to DV in SU treatment settings leads to negative health outcomes for DV survivors (Weaver et al., 2015). An additional study exploring the lived experiences of women with DV, problematic SU and mental health challenges found that co-occurring challenges increase barriers to services (Edmond et al., 2014). However, findings of this study are significantly limited as only 1 of the 50 participants had attempted to access SU treatment in the last 12 months, compared to other participants who reported only historical problematic SU.

An analysis of DV death reviews in New Zealand (Short et al., 2019) found that gaps in services, as highlighted above, may result in adverse health outcomes and barriers for women in need of support. This review specifically highlights the impacts of service gaps on Indigenous populations, noting additional barriers for clients related to systemic racism and oppression. In recognizing the limitations of siloed services to appropriately meet co-occurring needs, combined programming for DV and problematic SU has been a recommended best practice since the late 1990s (Macy et al., 2013). However, efforts towards this recommendation have varied across both DV and SU sectors.

Emerging Approaches to Address Co-Occurring DV and Problematic SU

In recognizing the interconnection of DV and SU, as well as the inability of siloed interventions to effectively treat their co-occurrence, recent approaches to service delivery and research in this area have focused on combined DV/SU interventions. This section presents research evidence on the rates of available combined interventions, their

effectiveness in addressing co-occurring DV and problematic SU, and barriers and limitations to their implementation.

Rates of Combined Interventions

In attempting to address more complex client needs, some DV agencies have begun incorporating harm reduction approaches to SU to better respond to DV survivors experiencing problematic SU. In the context of DV shelters, harm reduction refers to a value-neutral approach to SU in which SU is acknowledged without judgement and available supports prioritize reducing the potential harms associated with use without requiring abstinence or treatment seeking (Hovey & Scott, 2019). Harm reduction practices in these settings exist on a continuum and may include promoting open discussions about SU, allowing clients to access services while under the influence of substances, providing information and supplies to promote safer SU, needle exchange programs, and storing substances securely on site (Hovey et al., 2020).

One qualitative study on DV emergency shelter practices and policies related to opioid use across Rhode Island found that practices and policies, as well as staff training and knowledge to respond to opioid use in shelters, are inconsistent across agencies (Rothman et al., 2018). Inconsistencies in practices specifically include whether clients are asked about SU upon intake, whether clients are permitted to access services while under the influence of substances, and inconsistencies in external referral processes. Many participants in the study state that agency policies have shifted flexibly over time to adopt more harm reduction approaches as staff attitudes towards SU have changed. Practices related to SU among these agencies include referrals and cross-sector collaboration. However, none of the agencies in the study offer on-site SU supports.

Aiming to explore the current state of harm reduction in DV emergency shelters, Hovey et al.'s (2020) study examines the harm reduction practices of twenty-three shelters across Ontario. The study found that only three of the shelters represented in the study operate from entirely abstinence-based policies, while most shelters provide minimal to moderate harm reduction supports such as encouraging discussions about SU and referring clients to external SU services, such as those described in the following paragraphs. A minority of the shelters offer substantial SU services which include on-site SU counsellors, needle exchange programs, and dedicated space for monitored safe use on site. The study found that shelters with more frontline and relief staff are more likely to offer substantial SU practices, suggesting that increased capacity correlates with increased ability to implement harm reduction. The study additionally found that harm reduction practices improve the accessibility of services, increase client safety, and contribute to a non-judgemental shelter environment.

Similar to the DV sector, SU treatment agencies are beginning to incorporate attention to co-occurring needs. However, the field has been slow to implement changes. Important to note, SU treatment facilities, including the facilities represented in the two studies discussed below (Cohn & Najavits, 2014; Bennett et al., 2016), offer primarily abstinence-based services, promoting total abstinence from substances as both the goal and requirement of treatment (O'Leary et al., 2022). However, research on SU recovery also acknowledges the importance of harm reduction in promoting recovery from problematic SU, and harm reduction approaches are beginning to be implemented into some SU treatment settings (Hunt, 2012). Harm reduction approaches to treatment are shown to offer flexibility in intervention options, promoting client empowerment and self-determination in the

recovery process. Additionally, harm reduction focuses on attainable, hierarchical goals, understanding the potential harms (i.e. risk of relapse, fatal overdose, etc.) of focusing solely on abstinence as the goal of treatment (Hunt, 2012).

Similar to Capezza et al.'s (2014) findings, a nationally representative review of SU facilities across the U.S. found that only 36% of treatment facilities offer DV services (Cohn & Najavits, 2014). The study further found that facilities that are more likely to incorporate DV services are those that focus on addressing external psychosocial factors, as opposed to employing individual, medical model approaches. Another study examining secondary data from surveys of SU professionals on their experiences incorporating DV services into their work found that while SU treatment facilities report high rates of screening for DV, formal policies related to DV assessments and referral processes are less common (Bennett et al., 2016). The study concludes that screening alone is not sufficient to appropriately address co-occurring DV and problematic SU.

An additional way that service delivery is being adapted to meet complex needs is through collaboration across DV and SU sectors. One review on the ways that existing research on the intersection of DV and SU informs current programming found that collaboration across service sectors is strongly supported by professionals in both fields, although is being done minimally (Isobe et al., 2020). Further supporting this, two studies exploring the development of new interventions for treating this population in New Zealand (Holly & Horvath, 2012) and the U.S. (Tandon et al., 2020) both stress the importance of partnerships and collaboration between DV and SU sectors as key factors for program success.

Effectiveness of Combined Programming

Building upon the previous section, a number of studies have explored different measures of success of recently established combined DV/SU programming. These studies include exploring the effectiveness of DV agencies incorporating harm reduction approaches, SU treatment settings incorporating DV interventions, and the effectiveness of collaborative efforts across service sectors.

DV Agencies

All of the studies identified in the comprehensive review which explore DV shelter and housing program settings focus on initiatives to support SU needs in shelters and not necessarily on combined programming to treat problematic SU. However, this research highlights the awareness of and attempts to address the complexity of co-occurring needs in DV service settings.

One study interviewing former clients of a single Ontario DV shelter on their opinions of the shelter's harm reduction practices found that former clients, regardless of whether they used substances or not, were in strong support for harm reduction in the shelter, noting that it reduces barriers and promotes client self-determination (Hovey & Scott, 2019). The specific harm reduction practices of this agency include staff taking non-judgemental approaches to client SU, allowing clients to access the shelter while under the influence of substances, storing legal substances (e.g. alcohol, cannabis) on site, and providing safe use supplies. Participants, overall, spoke positively of their experiences of the shelter's harm reduction approaches, noting the environment as non-judgemental, respectful, and able to promote client safety for both clients who do and do not use substances. Specific recommendations and challenges noted by participants are presented in the following section.

Additionally, one review of an Irish DV shelter's first year incorporating similar harm reduction practices found that incorporating harm reduction increased client autonomy, fostered relationships between clients and staff, and led to zero instances of violence among clients, which was a significant concern among staff prior to the implementation of harm reduction (Morton et al., 2015). In a mixed-methods study on harm reduction practices in a DV housing program, Nnawulezi et al. (2018) note multiple benefits of incorporating harm reduction into the agency including reducing barriers, promoting client autonomy and self-determination, encouraging empathetic and non-judgemental approaches among staff, and an increased ability to provide the more intensive supports needed to treat co-occurring needs. While these studies provide important insight into how harm reduction can be incorporated into DV services, they lack insight into how combined programming, specifically, can be incorporated successfully into these settings.

SU Agencies

Research has also focused on the efforts and effectiveness of SU agencies in more fulsomely incorporating DV supports. Edwards et al. (2022) surveyed women living in a long-term abstinence-based residential program to assess rates of posttraumatic growth among women with histories of SU and DV and/or sexual violence. The program itself focuses primarily on treating problematic SU, with additional supports provided for DV. While the surveys captured only one point in time, results indicate high levels of posttraumatic growth among this population with the highest rates of posttraumatic growth seen in women reporting less recent DV. Posttraumatic growth among this sample specifically correlated with feeling a sense of community and connection to others within the

program. These findings suggest that long-term services which are able to address multiple client needs simultaneously while prioritizing connection and community are effective.

A clinical trial exploring client engagement within two different interventions to treat PTSD and alcohol use disorder among a sample of DV survivors supports the effectiveness of addressing needs concurrently (Myers et al., 2015). The study found that program participants who presented with higher severities of SU behaviours and PTSD symptoms at pre-treatment were more likely to engage in and complete the combined PTSD/SU treatment program than women with less severe SU behaviours and PTSD symptoms. Additionally, program participants describe the value of focusing on PTSD symptoms and SU simultaneously, noting poor outcomes in previously attempted treatment which lacked attention to co-occurring concerns. Similarly, in their trial exploring the efficacy of two DV interventions for women who use substances, Gilbert et al. (2015) found that the DV interventions which consider the impact of co-occurring SU increase accessibility and rates of receiving DV supports, as well as influenced a decrease in SU from baseline to 3 month follow up. While these studies support the effectiveness of combined interventions, they do not provide detail into the specific aspects of these programs which contribute to their success, making replicating their design and outcomes a challenge.

One study which does provide details into program design is Motz et al. (2019). This study analyzes the combined programming practices of a community-based SU prevention and early intervention agency in Toronto. The study focuses on the agency's "Breaking the Cycle" program which provides gender-specific services based on a developmental-relational approach which focuses on the influence of social systems, environment, and interpersonal relationships on client behaviour. The study found effectiveness in holistically addressing co-

occurring needs simultaneously and credits its effectiveness to the accessibility of having all needed services in one location as well as prioritizing the therapeutic relationship and promoting safety and self-regulation as core facets of programming (Motz et al., 2019).

Similarly, in their review of SAVA (substance abuse, violence, and HIV/AIDS) syndemic focused interventions in the U.S., Gilbert et al. (2023) found that interventions which focus on the intersection of problematic substance use, violence, and HIV/AIDS show strong efficacy in reducing rates of all three issues. Core elements of effective programming from this study include psychoeducation, screening for specific interactions between the three concerns, safety planning, social support, and promoting self-determination and self care.

Cross-Sector Collaboration

Additional studies have explored the effectiveness of cross-sector training programs to increase professional knowledge across DV and SU sectors (Mason et al., 2017; Stone et al., 2023). These studies both provide evidence that staff training can significantly improve knowledge and competencies, promote relationship building and collaboration across fields, and challenge misconceptions and attitudes towards either issue. Two studies on cross-sector collaboration and training within a maternal home visiting program had similar findings (Dauber et al., 2017, 2019). The first study, which examines the program's current practices, found low rates of screening and referrals due to a lack of practitioner knowledge and training, as well as a lack of available combined services for staff to refer to (Dauber et al., 2017). The second study employs a quasi-experimental design to explore the effectiveness of a new, combined approach to the program (Dauber et al., 2019). Although the results of this study are limited due to missing data, there is some evidence to support that increased

training on the co-occurrence of DV and SU increases the rates of service provider screening and discussing both issues with clients during initial assessments.

Humphreys et al. (2021) further explores the efficacy of prioritizing services which address co-occurring challenges across service sectors (DV, SU, child welfare, justice, health services, etc.) through a practice-led research project. The project involved collaboration across service sectors to explore the development and implementation of a new version of a previously established "Safe and Together" model of practice to support families experiencing DV, problematic SU, and mental health concerns by addressing the co-occurrence of these challenges. The project found effectiveness in focusing simultaneously on DV, SU, and mental health concerns, both for survivors as well as perpetrators within the families, through strengths-based perspectives. Compared to the previous version of the model, study participants note that focusing on co-occurring needs reduces barriers and vulnerabilities for families, supporting the efficacy of combined interventions which simultaneously address DV, SU, and mental health needs.

Barriers & Limitations

Multiple studies note barriers to implementing more comprehensive combined programming in DV settings, including limited funding and agency capacity (Hovey et al., 2020; Hovey & Scott, 2019; Morton et al., 2015; Nnawulezi et al., 2018). Barriers specific to DV emergency shelters include shelters being single staffed overnight (Hovey et al., 2020), lack of infrastructure to support safety related to SU (Morton et al., 2015), strict "zero-tolerance" policies for SU, and limits on allowed length of stays in shelters (Gezinski et al., 2021). Morton et al.'s (2015) study on the implementation of harm reduction in an Irish DV

shelter additionally highlights challenges around expanding services to incorporate SU while remaining within the prescribed mandate of the agency as a DV shelter.

An additional barrier to combined programming in DV settings is the influence of stigma and staff misconceptions about SU (Morrison et al., 2022; Stone et al., 2023). Gezinski et al. (2021) found that practitioners themselves demonstrate awareness of their lack of understanding of co-occurring challenges, however, note a lack of available training as contributing to further limitations (Gezinski et al. 2021). Staff beliefs that SU in shelters will increase safety risks for staff, other clients, and children are commonly cited and used as justification for not implementing harm reduction practices in shelters (Gezinski et al., 2021; Hovey et al., 2020; Hovey & Scott, 2019; Morton et al., 2015). As highlighted in these four studies, these fears are often fueled by stigma and misunderstandings about SU. These beliefs are further challenged by Morton et al.'s (2015) findings that implementing harm reduction practices (i.e. allowing clients to access services while under the influence of substances, providing safe use supplies, etc.) had no influence on rates of violence in shelter.

Studies in the comprehensive review cite similar barriers in incorporating DV supports into SU agencies including limited funding, agency capacity (Cohn & Najavits, 2014; Morrison et al., 2022) and SU practitioner misconceptions about DV (Hill et al., 2022). Concerns related to agency capacity include high staff turnover and leadership issues (Cohn & Najavits, 2014) and lack of resources and funding to implement appropriate staff training to address complex client needs (Cohn & Najavits, 2014; Morrison et al., 2022). Myers et al. (2015) additionally notes that many community agencies operate under tight budgets which impact the comprehensiveness of available services.

Similar to Morton et al.'s (2015) findings, an ongoing challenge noted by Motz et al. (2019) in offering holistic, combined programming is meeting the complexity of client needs within a narrow mandate of the agency. As described in the preliminary review, differences in philosophical and theoretical understandings of DV and SU have informed siloed approaches to practice and agency mandates (Isobe et al., 2020), making shifting service design a challenge. Cohn & Najavits (2014) and Mason et al. (2017) also add that agency mandates and philosophies are often influenced by different funding streams, which act as additional barriers to shifting service delivery.

Recommendations

This section describes the practice, education, and research recommendations of studies identified within the comprehensive review. These recommendations helped inform the design of the present study.

Practice Recommendations

The studies described in the comprehensive review offer recommendations to improving combined services and addressing noted limitations and barriers. The most common practice recommendation among the studies is a recommendation for holistic, combined programming that is intentionally designed to address the co-occurrence of DV and problematic SU (Edmond et al., 2014; Edwards et al., 2022; Hill et al., 2022; Isobe et al., 2020; Morrison et al., 2022; Short et al., 2019). Such recommendations include DV agencies incorporating services for mental health and SU (Edmond et al., 2014), as well as SU services incorporating services for DV (Edwards et al., 2022). Specific recommendations towards combined programming include the need for structural shifts among agencies to address the social implications of DV and SU (Gilbert et al., 2023), as well as actions that

align practices and policies across all levels of the agency (Hovey et al., 2020). Additional studies recommend that agencies should obtain additional resources and funding in order to effectively offer combined services (Cohn & Najavits, 2014; Gezinski et al., 2021).

Additional recommendations include increased collaboration, both among staff within a single program (Dauber et al., 2017), as well as across DV and SU sectors (Gezinski et al., 2021; Stone et al., 2021). Gezinski et al. (2021) specifically notes cross-sector collaboration as having potential to combat lack of available resources in the U.S. Increased screening for co-occurring challenges across sectors is also recommended (Fernandez-Montalvo et al., 2017; Holly & Horvath, 2012).

Studies on harm reduction practices in DV emergency shelters note specific practice recommendations to improve responses to SU including amending length of stay and zero-tolerance policies (Gezinski et al., 2021) and increasing staff presence/availability to clients (Hovey & Scott, 2019). Hovey and Scott (2019), in citing challenges to balance client SU needs with the safety of children and other residents, recommends elements of physical separation within the shelter to promote safety.

Education Recommendations

Four studies from the comprehensive review recommend additional staff training to address current program limitations (Cohn & Najavits, 2014; Gezinski et al., 2021; Phillips et al., 2021; Stone et al., 2021). Cohn and Najavits (2014) assert that increased provider training among SU treatment professionals will increase screening practices, aiding providers in individualizing treatment plans to address complexity. Gezinski et al. (2021) recommends training across both DV and SU sectors to improve provider responses to co-occurring needs. Study participants with lived experience of both DV and OUD similarly recommend cross-

sector training on the intersection of DV and SU for professionals across sectors including DV, SU, healthcare, justice, and child welfare (Phillips et al., 2021). Stone et al. (2021), in acknowledging the impact of stigma surrounding both DV and SU, expands on these recommendations to include public education and awareness initiatives beginning in school settings.

Research Recommendations

Existing literature highlights a need for future research in three key areas – further exploring client experiences of co-occurring DV/SU and related service needs, improving understandings of current agency practices, and further improving upon previously studied and developed screening tools, services, and programs.

Though past research has established a strong bi-directional relationship between DV and SU, research recommendations are suggested to further understand the nuance of intersecting needs. Future research is recommended to further explore the intersection of DV and specific presentations of SU including co-occurring OUD (Rothman et al., 2018), early onset and poly-substance use (Macy et al., 2013), and SU among pregnant/postpartum women (Morrison et al., 2022). Individual client characteristics and their relation to treatment completion and dropout rates is also recommended (Fernandez-Montalvo et al., 2017; Myers et al., 2015). Better understandings of the ways DV intersects with specific forms of SU and SU treatment outcomes is intended to better inform program development (Fernandez-Montalvo et al., 2017; Macy et al., 2013; Morrison et al., 2022; Myers et al., 2015; Rothman et al., 2018).

Two studies on home visiting programs (Dauber et al., 2017, 2019) recommend further research to validate and compare different versions of such programs to identify best

practices. Other noted studies, which assess the development and implementation of specific tools or programming to address co-occurring DV/SU, recommend additional research to further validate and scale up developed tools and programs (Gilbert et al., 2015; Hill et al., 2022; Tandon et al., 2020; Weaver et al., 2015).

Most relevant to the current study, Hovey and Scott (2019), whose study explores client experiences of harm reduction in a Canadian DV shelter, recommend similar research in other domestic violence shelters to analyze similarities and differences in shelter approaches to SU. The study additionally recommends studying service provider perspectives on harm reduction philosophy and practices in DV shelters. Hovey et al. (2020) further recommends studying the approaches of VAW agencies in national and international contexts to more broadly understand the current state of harm reduction in DV agencies. Other studies recommend that future research explore the ways that either low or high barrier services impact staff and survivor outcomes from and perspectives on programming (Nnawulezi et al., 2018) and how stigma surrounding SU impacts DV professionals' ability to serve clients (Stone et al., 2023). Edwards et al. (2022) also expresses research interest in better understanding how a sense of community, a key factor of client success, can be promoted in residential program settings.

Current Study Rationale

It becomes evident from the available research that there is an undisputable need for specialized services intentionally designed to support survivors at the intersection of DV and SU. However, as demonstrated within the literature review, combined service delivery is only recently emerging, and there are similar barriers across both DV and SU sectors to effective implementation (Gezinski et al., 2021; Hovey et al., 2020; Nnawulezi et al., 2018; Rothman

et al., 2018). Agencies that do offer combined programming demonstrate effectiveness in improving health and wellbeing outcomes for this population, however research in this area is limited (Isobe et al., 2020). While the studies presented in the comprehensive review support an argument for combined programming, there remains an important gap in literature describing the specific policies, approaches, and practices that inform effective combined programming. As such, there would be value in further research which explores the experiences of community-based agencies in offering combined DV/SU programming from the perspectives of professionals directly involved in service delivery.

The only study known to the researcher that has employed a qualitative interview approach to explore combined DV/SU programming from the perspective of service providers, which was excluded from the comprehensive review due to its population, is Mootz et al. (2022). This study focuses on combined programming for perpetrators of DV across multiple countries. Given that women experience the highest rates of DV victimization (Myers et al., 2015), exploring the programming needs of women-identified survivors is especially important. Further, only four identified studies explore the topic of programming for co-occurring DV and SU from a Canadian perspective (Hovey et al., 2020; Hovey & Scott, 2019; Mason et al., 2017; Motz et al., 2019), making further research in this area even more relevant.

Research is especially important given the worsening toxic drug crisis in Canada (Health Canada, 2019) and the added pressure and strain placed on agencies over the last three years resulting from the COVID-19 pandemic (Montesanti et al., 2022). Existing research demonstrates that COVID-19 has both increased global rates of DV (Kourti et al., 2023) and SU (Roberts et al., 2021) and has made needed services less accessible

(Montesanti et al., 2022). Due to the recent and unanticipated onset of the pandemic, none of the articles in either review explore or mention the impact of COVID-19 on service delivery. In acknowledging that the pandemic has significantly shifted community needs and placed unanticipated pressures on DV agencies across the country, research in this area is especially important as previous literature may no longer accurately reflect current programming.

As the present study explores combined service delivery among Canadian agencies, it is also important to acknowledge the specific historical and present influences of provincial social policy on DV and SU services. Social assistance policy in Canada has maintained unique differences across provinces throughout history (Boychuk, 1998). As a result, there remains important differences in the ways and extent to which each province prioritizes, funds, and manages social assistance policies (Boychuk, 1998). As such, it is expected that community-based agencies across Canada would experience differences in funding allocation, ability to offer comprehensive services, and potential limitations or barriers to service delivery. These differences must be considered in future research in order for findings to be readily applicable to practice.

Proposed Research

None of the existing research, to the researcher's knowledge, has qualitatively explored the current practices and experiences of community-based agencies in Canada in offering combined DV/SU programming from the perspectives of agency professionals. To address this knowledge gap, the current study interviews professionals from agencies that offer well established combined DV/SU programming with the aim of exploring promising practices in providing such programming to women-identified survivors of DV with co-occurring problematic SU. By establishing a fulsome understanding of the motivations,

theoretical approaches, practices, successes, and barriers in delivering combined programming to this population, this research aims to inform future program development in order strengthen the services available to women experiencing DV and problematic SU.

Methodology

The methodology for the present study is based on a constructivist paradigm, which acknowledges reality as subjective and socially constructed (Guba & Lincoln, 1994). Approaching the current study from this paradigm allowed for participants' multiple and nuanced perspectives and experiences to be captured without placing emphasis on uncovering one objective reality. Within this paradigm, Interpretive Description, in particular, was employed to interpret meanings from participants' subjective experiences to develop practical knowledge for use in professional settings (Thorne, 2016).

Employing an Interpretive Description approach allowed for flexibility in methodology, while upholding the necessary standards of rigorous qualitative research, such as orienting the present study within existing research and employing structured participant recruitment and data collection strategies (Thorn, 2016). Additionally, the present study acknowledges the ways that knowledge is socially constructed, values the experiential knowledge of participants as the key source of data, and acknowledges the relationship between researcher and data in informing study outcomes (Thorne, 2016). Interpretive Description was chosen over Qualitative Description (Sandelowski, 2000) due to its intention to extend past simple description of phenomenon to consider and describe the application and significance of findings for real world practice settings (Thorne, 2016).

Interpretive Description asserts itself as a "coherent organizing framework within which a range of various data collection and analytic strategies might be usefully deployed" (p. 81). As such, Thorne (2016) promotes borrowing from other design approaches, as long as the researcher meaningfully considers the intent and usefulness of techniques being employed. As such, the present study draws on various methodological approaches to data collection and analysis, including Grounded Theory (Glaser & Strauss, 1967) and Thematic

Analysis (Braun & Clarke, 2006), to meet the purpose of the study. While the methods of the present study share some similarities with Grounded Theory, including the use of constant comparative analysis, the present study does not set out nor claim to be a Grounded Theory study. Unlike Grounded Theory, which provides a structured approach to developing a social theory (Glaser & Strauss, 1967), Interpretive Description promotes flexibility, borrowing from other methodologies, to develop practical insights that can be readily applied to professional practice settings (Thorne, 2016). Through the balancing of theory and applied practice, the researcher hopes that the present study and potential future research building from this study will be simultaneously both grounded in theory and readily applicable to professional practice.

Data analysis was guided by a social-ecological framework which focuses on the interplay of multiple systems including individual, interpersonal, community, societal, etc. (Bronfenbrenner, 1979). This framework was chosen for the present study because it considers the ways that participants' subjective experiences are influenced by larger interconnected systems, as well as the ways that these larger systems are influenced by the direct practice of participants. As the present study specifically aims to develop practice knowledge for professional settings (Thorne, 2016), understanding how interconnected systems influence and are influenced by agency practices are significant to understanding the experience of agencies engaged in combined programming. In the present study, these interconnected systems include the global climate, political and geographical contexts, funding structures, relationships with other government, community, and healthcare organizations, as well as the social and cultural contexts of each community. This framework was thought to be appropriate for the present study given the researcher's interest in

understanding the influence of multiple social structures on participant experiences in direct practice, as well as identifying recommendations for improvement that involved change within multiple interconnected systems. Applying an overarching framework to data analysis, while maintaining a data-driven approach, is an approach consistent with Interpretive Description (Thorne et al., 2004).

Participants

The following sections outline who study participants could be and how they were reached for the study.

Eligibility Criteria

Participants were professionals across Canada presently working in social service organizations that serve women-identified survivors of DV experiencing problematic SU who were able to speak to their experience working within these organizations.

Participant eligibility included the following:

1. Currently employed at a DV, SU, or other community-based agency in Canada that provides support for both concerns.
2. Has been working at the agency for a minimum of three months.
3. Holds a credential supporting their provision of services, including a degree in psychology, counselling, social work, or a related discipline.
4. Works with women-identified adults (18+) and may also incorporate service provision for dependent children.
5. Must provide support to clients for concerns related to both being a survivor of DV and problematic SU.

The researcher acknowledges that professionals who have worked at agencies for longer than three months may be better suited to speak to their experiences working within those agencies. However, a minimum of three months was intentionally chosen to consider literature review findings that non-profit agencies experience high staff turnover rates (Cohn & Najavits, 2014). To mitigate potential barriers for participant recruitment among community-based agencies due to this, three months was determined to be an appropriate minimum length of time employed at the agency.

Sampling Methods

Due to the sparsity of agencies providing combined programming for DV and problematic SU, as stated in the literature review, participants were recruited using purposive, non-probability sampling methods. Human ethics approval was obtained through an application made to the Behavioural Research Ethics Board (BREB) at the University of British Columbia Okanagan Campus prior to participant recruitment. Initial contact was attempted to be made with provincial-level domestic violence agencies (e.g. BC Society of Transition Houses, Manitoba Association of Transition Houses) via email, with a request that the Recruitment Letter (Appendix A) be passed along to member agencies engaging in direct service delivery. Due to a low response rate from initial attempts, as well as responses stating that member DV agencies did not provide such services, the BREB application was amended to approve that contact be made directly via email with community-based agencies offering combined programming as identified through agency websites.

Provincial and national-level DV agency websites and government directories were utilized to identify DV agencies offering combined programming. Websites of identified agencies were scanned for relevance. Any agencies whose websites made mention of support

for addiction/SU were contacted and sent the Recruitment Letter (Appendix A). The researcher was intentional in exploring and contacting prospective participants across all provinces and territories. Multi-frame sampling was intentionally employed in the territories where provincial/territory-level DV agencies did not exist (Lohr, 2009). This was to promote the inclusion of underrepresented populations that are experiencing DV and SU but do not have access to the same resources as more populated areas. The researcher also explored provincial directories for SU services, although searches produced primarily government-run healthcare settings or private treatment facilities, which did not meet inclusion criteria for the study. Additional provincial-level directories for broadly defined organizations offering programming to women and families were also included as part of multi-frame sampling.

The researcher initially emailed the general contact email for each agency. Available contact information for DV shelters specifically was often limited to one email and/or phone number, presumptively due to the confidential nature of this work. If there was no response from the initial attempt, the researcher followed up with a phone call or email (Appendix B) to the general contact, or directly to a director or manager of programming, where available.

During initial contact with prospective participants, agencies were encouraged to pass along the Recruitment Letter (Appendix A) to other practitioners who may be suitable for participation as a means of snowball sampling. Interested individuals were asked to contact the researcher directly. This mitigated contact information being provided to the researcher without the consent of the person being recommended. At the end of participant interviews, participants were also asked about their knowledge of existing agencies offering combined services and were encouraged to pass along the Recruitment Letter to suitable contacts. Through this process, the researcher became connected with the coordinator of a national

community of practice focused on supporting harm reduction in DV shelters who offered to pass along the Recruitment Letter to known practitioners who met inclusion criteria for the study.

Sample Size

While most Interpretive Description studies employ a small sample size (5 to 30 participants), Thorne (2016) promotes the use of almost any sample size as long as it aligns with the purpose of the given study. Given that the purpose of the present study was to reflect a variety of perspectives across different service contexts in Canada, it was determined that purposively sampling a total of 8-10 service providers would be appropriate in providing a variety of perspectives.

Thorne (2016) cautions against the use of saturation in Interpretive Description. As such, theoretical sufficiency (Dey, 1999) was determined to be the most appropriate approach to determining sample size. Theoretical sufficiency acknowledges the richness of subjective experiences, promoting the development of a pragmatic argument that is well-supported by data, while acknowledging that findings do not encompass all that can be known about the topic (Dey, 1999). Interviews were collected until the researcher could confidently determine that a point of theoretical sufficiency was reached. While participants expectedly noted differences in practices and opinions across different service contexts, the researcher identified recurrent themes across interviews including theoretical approaches to practice, recent policy and practice shifts, and successes and barriers. Ultimately nine interviews were conducted. One of the nine interviews included two participants from the same agency, one director and one front-line staff member, to provide perspectives on both policy and

structural decisions of the agency, as well as experiences of front-line service delivery. All other participants were employed at different agencies.

Interviews

Prior to interviews being conducted, participants were provided with the consent form (Appendix C) via email. Upon receipt of the signed consent form, interview dates and times were scheduled. All interviews were conducted via video conferencing using a UBCO licensed Zoom account. At the start of each interview, participants were reminded of the consent form and the researcher introduced and positioned themself within the research. Any questions or concerns from participants were addressed prior to interviewing. Within the consent form participants were asked whether they permitted to digital audio recording of interviews. The researcher confirmed participant permission prior to beginning the recording of each interview. Interviews were formatted to be semi-structured and open-ended, utilizing an interview guide (Appendix D). Key topics of the interview guide included current agency approaches and practices to supporting clients experiencing co-occurring DV and problematic SU, and the successes, barriers, and recommendations for improvement related to these practices. Guiding questions were developed based on existing research-based knowledge and practice recommendations, as highlighted within the literature review. Proposed interview questions were adjusted for clarity throughout the interviews, as needed. The researcher was mindful to keep interviews within the agreed upon 1-hour time limit to be respectful of participant schedules. Aside from this consideration, interviews were concluded once all questions from the interview guide were completed, and the researcher had no further follow up questions from participants' answers. Participants were not offered an honorarium or any form of remuneration for taking part in the study.

Interview Dependability

In recognizing that knowledge in qualitative research is subjective and socially constructed, qualitative researchers are less concerned with demonstrating one objective 'truth' and more concerned with the 'trustworthiness' of research (Guba & Lincoln, 1986). As such, steps were taken in the research process to ensure interview dependability. One of the ways interview dependability was established was through standardized interview procedures. All interviews followed the same format and guiding questions and notes were taken following each interview to document the research process, reflect on personal biases in findings, and inform adaptations to future interviews.

Thorne (2016) recommends that steps be taken to limit the influence of communication and engagement techniques developed through clinical work. As such, the researcher pre-emptively took steps to learn how to appropriately facilitate research interviews to limit the influence of clinical interview styles developed from previous professional experience. Interview preparation included completing a qualitative research methods course at UBCO in which experience and feedback on interview skills and competencies was received and implemented into the present study. Prior to conducting interviews, the researcher engaged in practice sessions engaging with the technology to be utilized for scheduling, hosting, recording, and transcribing the interviews. This was done to promote familiarity with the technology and review interview processes prior to conducting interviews. The researcher also consulted with colleagues with previous experience conducting qualitative research interviews to seek feedback and insights on appropriate interview practices.

The researcher also considered the implications of past professional experience in the DV field on potential biases towards study findings. Some qualitative methodologies recommend "bracketing" researcher preconceptions (i.e. "setting aside" assumptions and past experiences so as not to influence the interview process). However, Interpretive Description acknowledges that participants and researcher inevitably have an influence on one another, meaning that the influence of the researcher's engagement in the research process cannot be entirely removed or "bracketed" (Thorne et al., 2004). In keeping with Thorne (2016) guidelines, researcher bias was instead addressed and limited by communicating the researcher's positioning in relation to the study at the beginning of participant interviews. Transparency into positionality included sharing how the researcher came to be interested in the topic, philosophical approaches, and relevant aspects of the researcher's identity. Attention was paid to ensure that interviews were approached from a neutral stance to limit influencing the conversation based on these biases (Thorne, 2016). The researcher reviewed and reflected on interview transcripts and incorporated lessons learned into subsequent interviews.

Data

This section outlines the approaches taken to collecting, handling, and analyzing data for the study.

Data Collection

Ethics approval was obtained prior to conducting interviews. Interview data was collected through audio recording interviews with permission from participants, in addition to taking written notes. Written notes were utilized as part of concurrent data collection and analysis, as discussed in the following section. Audio recordings were automatically

transcribed by Zoom transcription software and then manually reviewed for accuracy by the researcher. Although Thorne (2016) recommends manual transcription to encourage a more fulsome engagement with the data, transcription assistance was utilized for increased feasibility, although manual review of transcripts and coding was done in keeping with Thorne's (2016) recommendations. All personal participant information was removed from transcript content during the manual review process before coding began. Transcripts were stored in a secure UBCO OneDrive file.

As described, data collection ceased once a point of theoretical sufficiency was obtained. A total of nine interviews with ten service providers were conducted and made up the body of data that was utilized for data analysis. Below is a table highlighting the interviews collected.

Table 1: Overview of Data Collection Interviews

Participant #	**Date**	**Length of Interview**
1	Oct. 29, 2023	0:48:14
2	Oct. 30, 2023	0:53:26
3	Nov. 13, 2023	0:39:51
4	Nov. 17, 2023	0:47:34
5	Nov. 20, 2023	1:10:24
6	Nov. 24, 2023	0:37:38
7 & 8	Dec. 4, 2023	0:54:35
9	Dec. 18, 2023	0:58:56
10	Dec. 20, 2023	0:53:30

Due to the limited number of agencies across Canada which were identified to offer combined DV/SU programming, sharing any identifying information, such province or type of agency, for each participant could pose risks for participants being identified within the study. As such, presented instead are general participant demographics without identifiers

attached to individual participants in order to further assure the confidentiality of study participants.

Of the ten participants included in the present study, one was an Executive Director, five held management positions, three were Harm Reduction/Addiction Support Workers, and one held a different frontline staff position. Of the nine agencies represented in the study, four were emergency DV shelters, two were second stage DV agencies, and three were more generally defined community agencies which housed services for both DV and harm reduction, including the provision of either emergency or second stage DV shelter. While all agencies served women-identified clients, participants from five agencies also disclosed servicing clients of other genders. Additionally, while not explicitly asked about client demographics, three participants disclosed servicing a high percentage of Indigenous clients. Community sizes for these agencies ranged from small, rural communities under 15,000 people up to large metropolitan centers with populations upwards of 600,000 people and were situated across four different provinces – British Columbia, Alberta, Saskatchewan, and Ontario.

Data Analysis

Borrowing from Grounded Theory (Glaser & Strauss, 1967), Thorne (2016) asserts that engaging in some form of constant comparative analysis is essential to ensuring that "the ongoing engagement with data be strategically employed to confirm, test, explore, and expand on the conceptualizations that begin to form as soon as you enter the field" (Thorne, 2016, p. 109). In order to accomplish this, written notes were taken after each interview to compare each interview to the previous, slowly developing potential themes as data collection progressed. In this process, the researcher remained mindful not to pursue themes

prematurely or lead subsequent interviews in search of assumed patterns. As recommended by Thorne (2016), a slow pace was taken in manually reviewing transcriptions so that attention could be paid to the language and nuances of each. This process was fundamental in developing initial themes as it allowed the researcher "to develop a sense of the whole beyond the immediate impression of what it is that they contain" (Thorne, 2016, p. 158).

Once all interviews were complete and transcribed, interviews were uploaded into Nvivo software, backed up to a secure OneDrive account, for further analysis. Nvivo software was chosen due to its comprehensive usability for qualitative research. The next step of the data analysis process was an attempt to engage in thematic analysis (Braun & Clarke, 2006) to develop initial broad-based codes, in alignment with Thorne's (2016) guidelines. However, in the researcher's eagerness to begin the coding process, as well as this being the researcher's first attempt at data analysis, the researcher fell into a pattern against which Thorne (2016) cautions – engaging in overly meticulous coding too early in the coding process, leading to codes that were too precise and detailed to meaningfully capture significant themes in the data. In recognizing this mistake early on in the coding process, the researcher decided to review Thorne (2016) guidelines and, in taking Thorne et al. (2004)'s recommendation, sought external guidance throughout this process. The researcher decided to restart the coding process and relied consistently on the support of the primary thesis supervisor to ensure that the researcher was appropriately engaging in broad-based coding. Through the primary thesis supervisor, the researcher also became connected with a PhD candidate who had extensive experience conducting qualitative research, and utilizing Nvivo software, who also provided feedback and advice on the coding process.

In restarting the coding process after these additional steps were taken, the researcher was able to more appropriately employ thematic analysis to develop initial broad-based codes. This was evidenced by an increased ease and intuitiveness in the initial coding process. Through an inductive approach to thematic analysis (Braun & Clarke, 2006; Thorne, 2016), the first step taken by the researcher was analyzing each transcript in its entirety and coding pieces of data into initial broad-based codes. These initial codes included theoretical approaches, services/programs offered, agency policies, successes, and barriers. Using broad-based codes allowed the researcher to build an over-arching understanding and foundation of key themes before more detailed coding was conducted. In alignment with Thorne's (2016) recommendations, the researcher was intentional in labeling initial data groupings in generic terms, as noted above, compared to the first coding attempt, so as to not prematurely apply meanings to study findings. In this way, the researcher took a data-driven approach to coding process, as opposed to determining preset themes at the onset of data analysis (Braun & Clarke, 2006).

The next step of data analysis involved analyzing data pieces within each broad-based code to compare pieces of data within and across initial codes to slowly develop more detailed themes. Thorne (2016) highlights the importance of researchers engaging with data pieces critically, instead of simply organizing themes into codes. As such, the coding process included a consistent, back and forth process of analyzing the transcriptions and developed codes, adjusting, adding, and deleting codes in Nvivo, as well as writing and referencing back to written notes throughout the data analysis process to slowly begin developing themes. The researcher engaged in this process through a social-ecological lens, while allowing space for creativity in the coding process so as not to become overly confined by

this framework (Thorne, 2016). Nvivo software was helpful for this process, as codes could easily be altered or deleted, and large chunks of data could be moved between codes relatively seamlessly. Through this process a codebook was developed in Nvivo.

In being mindful that humans are naturally inclined to be grabbed by particular details, and potentially mislead in the coding process due to them (Thorne, 2016), the researcher also created a tab in the Nvivo software, separate from the main codes, to highlight pieces of data that stood out to the researcher as "quotable" or "attention grabbers" (Thorne, 2016). This tab ended up housing participant quotes which the researcher found particularly emotionally moving, highlighting participants' passion and commitment to supporting clients. In reflecting on these quotes, it became clear that the researcher's interest in these quotes was influenced by the researcher's own professional experiences and commitment to supporting survivors of DV. As such, this tab was used intentionally to ensure that the researcher could hang on to these seemingly important pieces of data while being mindful not to prematurely fit them into codes or organize codes around these pieces simply because they were deemed important by the researcher (Thorne, 2016). The majority of these "quotable" pieces eventually fit into the "client-centered" code and helped to further emphasize the importance of authentic relationship in promoting program successes, a key theme of findings. While these "quotable" pieces eventually proved to be significant to study findings, the researcher believes this approach was helpful in addressing researcher bias and remaining aligned to the purpose of the present study.

As the coding process progressed, the researcher continued to consider and think critically about the ways that particular codes or individual pieces of data related to other codes within the codebook. It was through this process of constant comparative analysis

(Glaser & Strauss, 1967) that a clear story began to emerge. It was at this stage in the coding process that understanding the data from a social-ecological framework became especially helpful in understanding patterns between pieces of data. As data analysis progressed, the researcher could increasingly identify themes related to interconnected systems at the macro, mezzo, and micro level which began to describe a coherent story of the interplay of larger social systems and individual participant perspectives on the shifts being seen at an agency level. This process allowed the researcher to meaningfully and meticulously reveal and document more precise themes throughout the data analysis process.

Thorne (2016) asserts that data analysis can be appropriately concluded once the researcher can develop a table of contents of findings and can articulately describe the logic by which findings are organized. In the present study, the researcher determined data analysis to be complete once coding groups, as revealed and developed in Nvivo software, displayed clear headings and subheadings which presented key themes in the data within a social-ecological systems framework. These key themes included motivations for implementing combined programming, theoretical approaches (trauma-informed, client-centered, harm reduction), agency programs, agency policies, shifts/changes in services, cross-sector collaboration, successes, barriers, recommendations, and ideal service models. From the code groupings present, the researcher could clearly communicate the flow of arguments within this framework and was able to begin developing a supporting introduction (Thorne, 2016).

Establishing Credibility

After each interview, participants were provided with the interview transcript for review. Clarifications or corrections, as provided by participants, were incorporated into final transcripts utilized in data analysis. Feedback on preliminary findings from data analysis was

sought from interview participants as a form of member checking (Thorne, 2016). During this process, the researcher took into consideration potential capacity limitations, as argued in the literature review and present study findings, for participants employed at community-based agencies to provide meaningful feedback. Each participant was presented the option to provide feedback on one of two versions of preliminary findings – one long form version that included direct participant quotations and elaborations on findings and a second, brief bullet-point version of the same content. The rationale for this was that requesting feedback on a long document may impose a workload barrier for participants employed at community-based agencies. This approach was proven effective as all participants who provided feedback on initial findings did so on the short form document.

Early coding debriefing occurred with the primary supervisor. This process helped ensure that the researcher was taking a data-driven approach to reduce the influence of researcher bias. The researcher also consulted with a PhD candidate who had extensive experience utilizing Nvivo software to debrief approaches to the coding process.

Findings

This chapter presents the key themes identified in the analysis. The chapter begins by exploring the motivations among participants' agencies to shift away from siloed, abstinence-based approaches to adopt harm reduction approaches and implement combined DV/SU programming. The chapter then describes the current practices of participant agencies in offering combined services including theoretical perspectives, policies and programs, and the role of cross-sector collaboration. This chapter concludes by exploring the successes and effectiveness of combined programming, barriers to implementation, and recommendations for future practice in this area.

Motivations for Implementing Combined Programming

Consistent with previous literature, the majority of the study participants reported that, in terms of SU supports, their agencies historically operated from abstinence-based approaches. This specifically meant offering supports exclusively for DV while excluding, policing, or penalizing clients who were actively using substances while engaging in the agency's services. This section describes the motivations that led participants' agencies to shift away from historical abstinence-based approaches to adopt harm reduction and implement combined DV/SU interventions. These motivations include an increased awareness of the barriers and limitations imposed by abstinence-based models and how these barriers have been exacerbated by increasing complex needs in participants' communities stemming from public health and social-structural challenges, including the COVID-19 pandemic. The impact of growing research knowledge of the interconnection of DV and problematic SU, including the influence of SU professionals entering the DV field, was also described as a key motivator among participants.

Program Barriers Exacerbated by Increasing Community Needs

A significant theme that arose during participant interviews was an observation from participants of a notable increase in complex, concurrent needs in their communities over recent years, including needs related to both DV and problematic SU. This theme was found consistently across all participants regardless of province or size of community. Participants particularly noted the toxic drug crisis (Health Canada, 2019), increased homelessness, lack of affordable housing, and increased mental health needs as concerns. Abstinence-based approaches were characterized as exclusionary and unsupportive of women experiencing active and/or problematic SU. However, recent increases in SU-related needs among clients brought further awareness to the ineffectiveness of abstinence-based approaches and placed pressure on participants' agencies to address these barriers. Describing the impact of increasing needs, one participant shared,

> *I've been involved with this agency since 2013, and I worked frontline initially. And when I worked frontline at the beginning of those years, I would say 1 in every 15 people was drinking alcohol, let alone, doing anything beyond alcohol. And if it was an intense drug, it was cocaine. Whereas now I think we see more and more folks coming in using substances and, therefore, we were turning more and more people away or deeming them as complicated. And it just didn't feel right.* (Participant 7, 16:13)

All participants described the ways that increased needs in their communities have impacted their ability to appropriately meet client needs within their organizations, noting a lack of capacity and funding to appropriately meet changing client needs. In speaking to the impact of this on staff, one participant shared,

We can't do everything. We used to be that organization that did everything, and staff were burning out like crazy. We just we don't have the capacity for it, and our stats have quadrupled in the last few years. For people accessing our services, there's not a lot of room for off the side of the desk stuff anymore. And it sucks. (Participant 10, 8:51)

Describing the specific ways that complex client needs have impacted the length of time that clients are remaining in emergency shelter, another participant shared,

So yeah, I would say, it is now very rare that we see a family whose only concern they're navigating is domestic violence. I mean poverty, addiction, mental health, are very, very commonly other factors that are at play. So that is increasing length of stay. And then just the housing crisis here in [province], I mean, it's everywhere, but to find safe affordable housing is really bad right now. So that's increasing stays. (Participant 5, 3:05)

Despite offering a variety of different services, it was a consistent finding across participants that, as needs in their communities have increased in recent years, so has the pressure for DV agencies to expand and shift service delivery towards harm reduction and combined interventions. As one participant described,

So, we continue to see that approximately 60% of the women who reside at [agency] use substances . . . And so, we really needed to change our policies to accommodate for that. If we're having those high amounts of substance use, but we're enforcing policies that punish people for using substances, we really aren't doing our job. (Participant 3, 3:44)

Some participants shared the opinion that as complex, concurrent needs continue to grow in their communities, DV agencies no longer have the choice to be entirely abstinence-based in order to appropriately meet the needs of their communities. One participant described a growing interest in harm reduction among other DV agencies in their province and, when asked about the motivation of these agencies to incorporate harm reduction strategies, the participant shared,

> *I think it's in response to people not knowing what to do anymore, because it is so common, and you can't avoid it. And people are still worried about overdose and they're confronting overdoses, and they had no plan.* (Participant 2, 47:57)

COVID-19 Pandemic

While participant interviews did not specifically ask about COVID-19, over half of participants also described the ways that the pandemic has both contributed to this increase in complex needs in their communities and negatively impacted their service delivery. While previous literature shows that the pandemic increased global rates of DV (Kourti et al., 2023) and SU (Roberts et al., 2021), participants particularly noted an increase in complex, concurrent needs following the pandemic. The lasting impacts are described by one participant,

> *It never used to be like this, not this bad, anyway. But everything is getting worse in [community] including substances, including violence. I thought that COVID was the worst for violence in relationships and substances. When COVID was over, we were like "we're going to be able to move on from this," and I don't think it's gotten any better.* (Participant 10, 48:46)

Service delivery experiences during the pandemic, as noted by participants, aligned with previous literature findings from a study in Alberta which found that the pandemic increased rules and restrictions, as well as limited the availability of existing programs (Montesanti et al., 2022). For example, one participant explained,

> *And then when the pandemic hit, [provincial organization] - and I totally understand it - they really expected us and directed us to tighten up our services . . . And women were restricted during the day, even on how long they could be gone and where they were going and all of that.* (Participant 4, 24:55)

Another participant additionally described the impact of the pandemic on rules within a DV shelter setting,

> *a lot of the policy and procedure that had been in place before, but then even reinforced more during COVID, put most of our frontline staff into this judge and jury position. They weren't able to build relationship with clients because they were "you can't do this. You can't do that. You have to be back here" like that's not conducive to relationship or even safety.* (Participant 5, 22:43)

Capacity challenges were additionally noted by another participant,

> *During the pandemic, we had to limit our capacities based on the availability of people sharing rooms. Now we have fully opened back up again. We have noticed that we are consistently at capacity. And the crisis calls for admission, unfortunately, don't stop. We unfortunately have to turn away quite a bit of women.* (Participant 1, 3:42)

As demonstrated, the pandemic was characterized as having serious, unanticipated, and long-lasting impacts on participants' agencies, impacting the wellbeing of clients as well as the ability of agencies to meaningfully support them. This unanticipated shift contributed

to an increased awareness of the ineffectiveness of abstinence-based approaches to meet client needs and was a key motivator for shifts towards incorporating harm reduction approaches.

Increased Research & Awareness Contributing to Shifts in Practice

In addition to increasing complex needs in their communities, participants also described how an increase in research knowledge and general awareness of the interconnection of DV and SU has motivated shifts towards harm reduction and combined interventions. For example, one participant described how this increased understanding has influenced policy changes at their agency,

> *We have moved away from the traditional housing models of sober living, zero tolerance. We've really learned that there is that connection between violence and substance use. And it's really unfair and unrealistic to expect women who have faced such extreme trauma to really just cope with it when they don't know coping skills.* (Participant 3, 2:04)

Another participant echoed,

> *And I think more research has come out over time and more knowledge over time in our sector to say, there's an intersection between these two things. You can't just deny one without acknowledging the other. So as an agency, we recognized that and said we need to be doing a better job of supporting these women and children.* (Participant 7, 17:02)

Another participant described the connection between increased understanding and language to describe co-occurring DV and SU and the services available to appropriately meet concurrent needs,

It's new for us as service providers to build that capacity and build those support. But this isn't new at all. Domestic violence and substance use have always been interconnected. We just now have the language for it, or the services for it, or we're starting to. (Participant 9, 57:51)

In speaking to the role of increased awareness and research as motiving policy and practice changes, other participants further described their understandings of the interconnection of DV and SU,

Yeah, often domestic violence or intimate partner violence and gender-based violence are wrapped up with substance use. There's a very common link between them. So, either it's that substances were being used at the time of assault, or they're often a precursor for assault if there's physical violence or sexual violence involved. They sometimes can be the carrot that keeps a woman in their relationship if their partner is providing the substances, or is their access point to that, and they're limiting their contact to the outside world due to control and coercion. (Participant 2, 14:26)

Similarly, another participant shared,

I think the complexity is around often addiction is connected to the violence. So, whether they're using it to cope, but I would say even more commonly the addiction is a part of the violence . . . They weren't using before, then they meet this guy who they start to use with. And then it's like this is how you're using. This is what we do together, and then it's held over them. The complexity of it being a tactic used to perpetuate the violence, there's just the layers to untangle that are just really intense. I think that that's it, is that the addiction is somehow connected to the abuse and so it's harder to leave. (Participant 5, 53:22)

For some agencies, this deeper understanding of SU and harm reduction, as well as the need to address DV and problematic SU concurrently, was introduced into the agency by newly onboarded staff members who had prior training and experience working in the SU sector. Three participants described this expertise among individual staff as contributing to important changes in staff competencies and day-to-day practices in their agencies. When asked about the motivation to implement harm reduction strategies, one participant answered,

> *There has been staff who've come on who have the mental health and addictions training. Like specific education from the colleges and universities that has really helped.* (Participant 1, 17:57)

Another participant echoed,

> *there has actually been no real direction from management about harm reduction. We are fortunate to have a social worker who worked in [SU treatment agency] who is very well versed with addiction and understands that harm reduction is needed.* (Participant 6, 7:50)

Current Approaches & Practice to Addressing Co-Occurring DV and Problematic SU

Influenced by the above noted motivations, this section describes the specific ways that participants' agencies have shifted towards combined interventions to address co-occurring DV and problematic SU among clients including (1) theoretical approaches; (2) policies and programming; and (3) the role of cross-sector collaboration.

Theoretical Approaches

Participants consistently described personal approaches to practice, as well as agency values, that aligned with being trauma-informed, client-centred and based in harm reduction

principles. This section presents the ways that these three theoretical approaches inform current policies and practices.

Trauma-Informed Practice

Participants emphasized trauma-informed approaches, which acknowledge and respond to the impacts of trauma, as being central to their agencies' approach to practice, both historically and presently. One participant described the importance of a trauma-informed approach in understanding survivors' experiences of DV,

> *And we understand trauma. We understand that to keep yourself housed, you're going go back to that relationship every single time. That's okay, we're here to help when you're ready. We understand mental health and we get it when our clients tell us stories.* (Participant 10, 31:59)

Another participant described how this understanding of DV from a trauma-informed lens has influenced their approach to enforcing shelter rules,

> *If you consider women who are coming to shelter and they're fleeing domestic violence, and you are telling them they can't do "abcd" and as trauma survivors their abuser has most likely been telling them, "you can't do that," we understand that doesn't equate to a healing relationship and building rapport.* (Participant 1, 13:09)

In acknowledging the link between DV and SU, participants also described how trauma-informed approaches support their work with DV survivors experiencing problematic SU. One participant explained,

> *We take a trauma informed approach as well. So, there should be zero shame or stigma. That's not trauma informed. Blaming people for their addiction, not trauma informed.* (Participant 6, 29:07)

Client-Centered Approaches

In addition to being trauma-informed, participants also described the importance of client-centered approaches in better responding to the needs of DV clients experiencing problematic SU. When referencing client-centered approaches, participants described practices that prioritized clients' values and needs as opposed to imposing practitioner/agency expectations on them. One participant described what a client-centered approach to supporting SU needs looks like specific to their role,

> *Not all the women who come in want inpatient treatment, and that is their choice. We support whether they want that inpatient treatment, or they want the outpatient treatment, or they don't want anything. We support their choice; we are a client-led agency.* (Participant 1, 7:21)

Another participant shared how being client-centered informed their approach to policies in responding to clients experiencing active SU,

> *It really is about trying to be client centered and not have those policies hinder everything. Which is what we said when we terminated the 3 nights out policy. Because for some folks it might have been appropriate, but to have it a blanket "this is fits everybody," it really didn't make sense.* (Participant 4, 28:58)

In addition to prioritizing client needs, another key finding related to client-centered care was an emphasis on engaging clients with authenticity, honesty, and respect, viewing clients as whole people without reducing them to a singular DV or SU service need. Participants were less likely to explicitly define these practices as "client-centered" compared to efforts to prioritize individual client needs and values. However, the authenticity, acceptance, and empathy demonstrated within these practices are key features of client-

centered care (Rothery & Tutty, 2016). The importance of authentic relationships arose consistently across all interviews and was noted as a major contributor to program successes. One participant highlighted the importance of authentic relationships,

> *Healing happens in connection to other people, whether to culture, to whatever it is. So that really was very much the shared vision of everyone here. Everyone very much knows that our work happens in relationship . . . From there we were able to build to if you are in relationship with the women we're serving, there is some safety there.* (Participant 5, 29:30)

Another participant added,

> *And our clients know that we also have open communication with our clients. We're not going to judge you, tell us the truth if you want. We're going to work with you in a non-judgmental way. And our clients know that we genuinely care about them.* (Participant 10, 30:07)

Another participant expressed a similar sentiment towards supporting clients,

> *It's always being mindful, like this is a person, and this is their real life. We're here Monday to Friday, 8 to 4, 8 to 5, they're here 24/7. They don't get a break from this. This is their life. So how do we help? How do we ease some of that pain and discomfort? And how do we set up safety barriers for them so that they don't get hurt, whether that is with an ex-partner or with drug use?* (Participant 6, 30:14)

One participant shared a client example which highlights the importance of establishing authentic relationships to create safety and reduce stigma,

> *And then [client's disclosure of SU] came out, and then she was like "this is what I'm doing. This is how far I've gone, I need help." But it was because of all those other*

little times where staff were like "are you okay? We're here for you. What do you need?" And not necessarily always focusing on the substance use either, it's just in general. And she knew that she was safe, that she could come and say this is what is happening. (Participant 8, 34:21)

Another participant emphasized a need to address shame surrounding both DV and SU from an honest, respectful place,

And I think for me, that's a parallel with addiction. There's so much shame. Yeah, the parallels between the two are just undeniable. Like the shame around living in violence or using substances, keeps people in those unsafe situations. So, if we could reduce the shame, and it had nothing to do with people's value, and that they were met where they were at when they came to us, we would live in a very different world, I think. (Participant 5, 52:29)

Harm Reduction

While trauma-informed and client-centered approaches were well established within participants' agencies, incorporating harm reduction approaches, particularly to client needs related to SU, was a newer practice. The majority of participants described the most significant shift in agency practices to better respond to changing community needs as being a shift from primarily abstinence-based models of practice to models informed by harm reduction. This was consistent for all except two participants whose agencies already offered harm reduction services as separate elements of existing programming. Participants' understandings and descriptions of harm reduction were consistent and aligned with Hovey and Scott's (2019) description as a value neutral approach to SU that aims to promote client safety and reduce the potential harms related to SU behaviour without requiring abstinence or

treatment seeking. One participant described this shift in approach towards a harm reduction model,

> *...we moved away from the model of practice of "if you use substances your housing could be jeopardized." And we have instead worked through a new model of supporting people with their substance use and not punishing or ignoring it, and instead really addressing and working through them with the client as the main focus.* (Participant 3, 2:46)

While some participants described harm reduction approaches as being new to their agencies, other participants noted that harm reduction practices have long been incorporated into the agency to support DV, but it was applying these same principles to SU which was new. As one participant described,

> *it doesn't necessarily just apply to addiction either. Harm reduction in life in general. I mean at the core, what we do when we work with women who are fleeing violence is "what is safest? What is the least harmful for you?" So really embedding that and threading it through all of our practice.* (Participant 6, 9:18)

It was a consistent finding across all participants that adopting harm reduction strategies meant supporting clients with their SU in ways that prioritized safety and reduced potential harms. One participant spoke to the ways that incorporating harm reduction strategies has increased safety for clients using substances,

> *But having a harm reduction strategy in place in shelter actually, probably makes it more likely that we're going to prevent overdoses, because we're more likely to be aware of someone's substance use, the level of use, and the risks that they present in*

that area. And we're going be more concerned. We're going to be watching more closely if we have to. (Participant 2, 30:01)

Another participant provided an example of what this increased safety looks like in practice,

So, the more that we can get comfortable with having those conversations, and that they trust that if they come to us and say, "hey I've used today." That we'll say, "that's okay, we're going to do more wellness checks then tonight." And that's made a pretty big difference. And then it also builds that trust and that connection. (Participant 9, 20:02)

The introduction of harm reduction strategies was also intended to reduce existing barriers for women engaging in SU in accessing participants' agencies and programs. One participant highlighted this ability to reduce barriers for clients who use substances,

Honestly, I haven't seen a moment where we have seen someone and been like "oh, they shouldn't come to [agency]". I think with our low barrier, we are really leaning to women's needs. (Participant 3, 23:58)

Policies & Programming

Shifts towards harm reduction models and combined interventions also influenced and required shifts in formal policies and programs. Reflecting the diversity of agencies and specific geographical and political contexts, each agency reflected in the present study navigated and introduced these changes in different ways. This section outlines the process of shifting services, as well as presents the current policies and available programs offered at participants' agencies to support clients experiencing concurrent DV and problematic SU.

Process of Shifting Services

The process by which formal policies and practices have shifted towards combined interventions varied across participant agencies. These differences included the direction from which the push to change agency practices came from, the pace and ease of the transition, and the current state of formal policies. Three participants described these changes as coming from the top down, with management introducing and leading changes towards harm reduction models. For example, when asked about the direction from which the push to shift services came from, one participant explained,

> *I think the Board really wanted to push a harm reduction focus. They were very in support of harm reduction. And I think it was our Executive Director, as well. She is very forward on harm reduction and it's really a good move.* (Participant 3, 10:41)

Another three agencies described gradual changes among frontline staff in slowly adopting harm reduction approaches, which then influenced management to also adopt these approaches. One participant described this shift as a collaborative process between management and front-line staff, and the remaining two agencies described no shifts in formal policies, as their agencies already housed harm reduction services. The ease of this transition was dependent on staff's openness to adopting harm reduction models, as will be described in a subsequent section.

While a minority of participants explained that formal policy changes were introduced first with frontline practices following afterwards, the majority of participants described gradual shifts in day-to-day practice towards a harm reduction model, while formal policies lagged behind. At the time of conducting interviews, participants described being in

different places in terms of what formal policies existed relating to SU. One participant described this process,

> *I've been here for about a year and a half, and we have pretty much changed everything. And we've done it just like "we're going to try something and see how it works." And so, we're just starting to make sure our policies match our practice. So that's all coming. But we don't have it right now. Honestly, our policies still right now say that if someone comes to shelter drunk, they're asked to leave immediately. We do not practice that way at all.* (Participant 5, 20:30)

One participant described the importance of fluidity in their formal policies in order to most appropriately meet client needs, including needs related to SU,

> *For the folks out here, I always say our policies are fluid. That this is the guideline, but if you have a situation and you feel like the policy is not going to be helpful, and you have another solution, then let's go with that. It really is about trying to be client centered and not have those policies hinder everything.* (Participant 4, 28:22)

Another participant described the process of reviewing and updating language in formal policies to reflect current harm reduction practices,

> *there were some parts that we took out from old policy that would just be like "your stay could be jeopardized if the women's behavior on substances affects others" and then in brackets things like fighting - it was very stigmatizing things that you can do on substances, so we took it out because it's not needed.* (Participant 3, 9:46)

Participants from the two agencies that previously housed harm reduction services did not describe any formal shifts in policy but did note an increase in staff capacity to support

clients within those policies. For example, responding to questions about the agency's history of harm reduction, one participant responded,

> *I mean, I don't know the entire history, but I know before I was brought in, they definitely weren't doing abstinence-based. It definitely was more of a low barrier shelter, but I would say that our capacity changed. Not just my role, but the organization in general, was like "we are adopting this, and we are adopting this not halfway."* (Participant 9, 12:54)

Further highlighting inconsistencies in the ways that DV agencies are shifting to better respond to SU needs, participants described a lack of consistency in harm reduction practices across other DV agencies in their provinces. For example, one participant described their understanding of the history and present practices of community agencies engaged in DV work,

> *There's been a lot of changes in our sector over the years, I would say, from the time a lot of organizations started. It was just very black and white, and addictions was just not something you could ever come in and have. People were like, "that's just not going to work." But having said that, just being on the board and hearing all of the different organizations, we are all over the place in terms of a sector and with organizations' acceptance of it, and where they're at.* (Participant 4, 33:41)

Another participant commented on their understanding of available services in their province,

> *In terms of shelters, I do still believe that is a big gap. I believe that shelters do ultimately work from a trauma informed approach, but there still is that lack of harm reduction.* (Participant 3, 32:12)

Additionally, an interesting trend in participant interviews, which further highlights the individual ways agencies have been navigating these shifts, was a finding that participant knowledge of other agencies offering combined DV/SU programming was relatively limited. Three participants disclosed having limited knowledge of any agencies offering such services and only a minority of participants were able to name a known agency offering such programming. Two of the agencies reflected in the current study were actively involved in a national community of practice focused on incorporating harm reduction strategies into DV shelters and both spoke to a national understanding of current practices. While a number of participants did describe engaging in information sharing with other DV agencies in their provinces, this finding supports the fact that understandings of combined DV/SU programming and best practices remains limited, leaving agencies to navigate practice shifts on a largely individual basis.

Policies & Procedures Related to SU

The one policy that was held consistently across all, but one, agency was that using substances on shelter/agency property was not permitted, though some agencies had more lax policies related to cannabis and alcohol use on site. The rationale behind these policies was ensuring client safety, noting limited staff capacity and infrastructure to monitor use safely as concerns. Only one participant did not explicitly state that use on property was prohibited, however did not provide details on specific policies surrounding this.

While using substances on site was not permitted, it was a common practice across all participants that clients were permitted to access services while under the influence of substances, given the extent of their SU did not pose safety risks that exceeded the capacity of the agency to ensure client safety. As an additional safety measure, four participants

described engaging in wellness checks to ensure the safety of clients who had recently used substances. One participant explained,

> *One of the other things that we changed in our practice is doing wellness checks . . . So, if we haven't seen a woman by 10 o'clock in the morning, we do knock on the door, and we do want a response. And then depending on the level of usage, we might do more than that during the day, just to be safe.* (Participant 4, 46:14)

A minority of participants described engaging in room checks where staff would check for and ask clients to remove substances found on shelter property. The process for room checks was described by one participant,

> *We only conduct room searches if we have given a warning, there's ample reason to believe the woman is storing unsafe drugs in her bedroom and is using in her bedroom. If she's around, we'll give her the opportunity to witness the search. We don't just go through every piece of what she has and make a big mess. It's as respectful as we can be. We also give her the opportunity just to hand over any drugs she may have stored in the room or unclean needles, things like that. And that we dispose of them safely then carry on.* (Participant 2, 25:11)

All participants who did not allow SU on site described that if clients did use substances on agency property, conversation and safety planning from a harm reduction approach would be employed as opposed to historical practices of immediately discharging clients from services. One participant described their approach to these policies,

> *We haven't quite got to the spot to say you can use on site. We don't have any sort of safe use places on site outside of marijuana and nicotine. They can smoke marijuana and nicotine on site. For folks that we learn are using within their bedrooms, then we*

just have an honest conversation and say, "you know it's our understanding that you're using in your bedroom. We don't want to have any sort of negative consequences or discipline to that. But we want to make sure that you're staying safe. And these are our worries about you using in your room and can we look at other safe options?" (Participant 7, 11:30)

Another participant echoed,

In cases where we might have suspicion that the client is bringing substances onto property, because we are harm reduction, we don't want to immediately discharge the clients if we are able to work with them on this, because ultimately that doesn't fulfill their need of being supported in the shelter. (Participant 1, 11:30)

Another participant described their harm reduction approach to these policies,

We don't have any policy around having alcohol on site, but we would prefer that people not use in the unit. Alcohol is a tricky one. But if they're using on site, it's "okay, there are kids here. So how do we make it safe for kids and how we do we make it safe for you?" That's kind of where we're at right now. (Participant 6, 4:40)

One participant described the positive impact of these new policies on supporting safety related to DV,

Also, women if they are using substances, their housing is not jeopardized just for using. So, I think that's huge because if we find a woman is using substances and then we evict her, where is she going to go? Probably back to her partner and back to that traumatic situation again. (Participant 3, 12:31)

Participants did describe cases where clients' SU needs exceeded the capacity of the agency to ensure safety which resulted in discharge from services and referrals to more

appropriate supports. In these cases, participants described steps that were taken to move clients on from services in respectful, client-centered ways,

> *The other piece is, if we get to the point where we say "we've had all these conversations. We don't feel like we're able to serve your needs in the way that you need them." The way we do a departure is, we will say, "okay, it's Wednesday morning. By Friday afternoon we're going to need to ask you to depart. These are the boundaries we'd like to put in place around you being here for that time," which is whatever the safety plan is. And then we do that work on their behalf to find them another place to go.* (Participant 5, 12:22)

Another participant described this process,

> *Because, truly, there may be some folks so heavily into their substance use or addiction that they're not quite ready for us. But rather than shutting our door and saying, "we're not right for you," we try to warmly hand them off to an addiction service and say, "come back to us when you have that a bit more settled and within your control and then we'll look at how we can support you. Or if you feel that you have your addiction or substance use under control and managed, then we'll maintain our service with you."* (Participant 7, 10:06)

Participants also described changes made to general shelter policies which, while existing to support safety needs related to DV, created barriers for women who used substances. For example, one participant described their motivation to eradicate a historical "three nights out" policy,

> *So back in the day when I started at the [agency], the policy was that if a woman spent 3 nights away from the shelter, her file was closed because she was*

demonstrating that she felt safe, and that she had somewhere to go. So that was one of the policies we looked at with harm reduction because at that time we also told women if they came back under the influence, they would be asked to leave. So, it was just not very supportive. If women felt they needed to go and use, and then tried to be respectful and not come back, then we're going to tell them to leave because they've been out too much. So, the 3 nights out policy was eliminated. (Participant 4, 21:12)

Another participant described a similar challenge with policies which enforced a 12:30am curfew,

Clients can't have substances on property, so, there's that space and time where someone is not able to use which could be difficult for someone struggling with substance use . . . Clients who use substances usually are more willing to take that risk to be like, "okay, I'm not going to come back at this time because I need to fulfill my needs", which is understandable. It's difficult if the expectation is very rigid for someone who might not be able to meet that expectation, but then that expectation also exists for safety purposes. (Participant 1, 12:36)

Both of these policies highlight the challenges and necessity of balancing safety needs related to DV, while remaining open and flexible in responding to SU needs from a harm reduction perspective.

SU Specific Programs & Services

In addition to changes to general policies and practice, four of the agencies reflected in the present study had developed a specific addiction/harm reduction staff position within their DV program. One other agency, who was the only agency to have a nurse practitioner on site, described the role of the nurse practitioner as providing SU supports that aligned with

addiction/harm reduction roles in other agencies. In one of the two agencies that already housed separate harm reduction services, the participant described that the agency maintained separation between their DV and harm reduction programs, although staff from each program engaged in regular collaboration. The specific tasks of addiction/harm reduction staff were described by participants,

> *A lot of it is accessing treatment, I do a lot of referrals for treatments. We had a harm reduction group that we ran for a while as well. So that was a support group, but not focused on abstinence. It was focused on skills and coping, education around substance use, things like that. So, that was our in-house programming and then getting people on methadone and suboxone is a huge part of my job. And providing transportation when we do that.* (Participant 9, 5:25)

This same participant also described being able to conduct drug checking, a role less common among other participants,

> *I do testing with people, so we're checking their actual substances and I'm teaching them how to do that. We're having conversations around if you use outside the building, where are you using, with who, can you come check in with me afterwards so that we can do wellness checks? How much are you using? Are you getting it from a new dealer? Okay, well then, let's test it. So just things like that, we just have a lot more support with.* (Participant 9, 34:02)

Another participant described additional aspects of their role,

> *I also do one on one counseling with the women. Narcan and naloxone training as well. I also provide transportation and accompaniment to harm reduction case*

planning. A lot of that is going to the opioid addiction treatment clinic here in [city]. (Participant 3, 5:41)

The remaining three agencies, while they did not have a dedicated staff position for addiction/harm reduction, described engaging in similar case management practices to support clients experiencing problematic SU. However, participants who held SU specific roles noted the benefits of having this role separated from regular case planning, including,

> *But one of the cool parts about my job is that I can be separated from all of the other stuff. So, when they're looking for housing, or they're working with child protection or whatever it is, working to access supports for domestic violence, for the substance use they have somebody who's kind of safe and separated from some of that other stuff. So, it feels like they can be a little bit more honest about those challenges because there's a lot of stigma that comes with that.* (Participant 9, 3:07)

Other participants whose agencies housed harm reduction/addictions staff roles noted increased capacity when this role was separate for other programming,

> *So, when you're in that residential office, and you're working with 45 residents, it's really hard to find the time to dedicate to somebody to sit down and do a really thorough, uninterrupted check-in. So, to have [the harm reduction] position, it's nice because then she can have that dedicated time to sit down with folks and have uninterrupted conversations where she's able to completely connect.* (Participant 7, 36:53)

Cross-Sector Collaboration

In addition to internal shifts to better meet client needs, participants also described the importance of relying on community partners to effectively support clients experiencing both

DV and problematic SU. To address the limitations of ensuring the physical safety of clients using substances, agencies relied on referrals to hospitals, detox programs, and supervised consumption sites, where available. This process was described by one participant,

> *It can be difficult dealing with someone who is struggling with substance use and going through withdrawal and not having the medical support . . . We are quite fortunate; we have a hospital that is very close to us. In most circumstances, what we do is we would send them to the hospital, save their bed, they come back and resume programming*. (Participant 1, 21:08)

Referrals to other SU services including inpatient and outpatient treatment programs, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), community clinics, and addictions counselling were also common. However, every participant noted limitations of and/or barriers to accessing SU services including long waitlists, lack of needed services, inadequacy of available services to meet needs, and lack of available childcare. For example, one participant shared,

> *This, combined with a lack of treatment options, the lack of just any kind of interventions that are meaningful for people, that meet people where they're at. Or not so much the lack - it's the capacity to respond that, I think, is extremely diminished by the ones that are there.* (Participant 2, 11:23)

Additionally, participants described barriers related to stigma from external professionals and services related to both DV and SU. One participant described their clients' experiences accessing external services,

we used to send all of our clients who needed any sort of care or referrals to a clinic that's within walking distance. And we had terrible experiences with them, the way they would talk to our clients. (Participant 5, 46:08)

In response to this, some participants expressed a desire for increased relationships to better meet client needs,

Because, earlier I said, we would work with someone to triage them over to addiction services if that was their primary need and then bring them back to us. In theory, that's a great plan. But I would love to get to a point where maybe our local residential treatment program had a bed on hold for our agency. (Participant 7, 20:57)

As reflected in previous literature (Holly & Horvath, 2012; Tandon et al., 2020), participants also described the value in cross-sector collaboration and partnerships to help bridge DV and SU sectors through collaborative case planning and training. One participant highlighted the necessity of these practices to bridge DV and SU sectors, noting,

the people that work with domestic violence primarily, don't really know how to treat substance use, and then the people who treat substance use don't really know how to deal with domestic violence. So, there's the problem with both of those things when there's those concurrent issues going on. (Participant 9, 39:03)

One participant described what this collaboration and knowledge sharing looks like in practice,

Sometimes other agencies will do in service with us or some of our people are already connected to other agencies that work with them on their addiction. Our big one

would be our outpatient adult addiction services. So, our staff work with the woman's case worker and they'll learn from them. (Participant 6, 10:11)

Another approach to collaborative cross-sector case planning was described by one participant,

And then, if they have [child protective services] involved, if they have external community supports, that's where we do what we call a joint meeting, where we bring everyone together. We discuss it, especially if there's children involved, that becomes a [child protective services] conversation. And it's overall like [participant 7] was saying, how can we support you? (Participant 8, 13:26)

Referrals and advocacy related to housing, income support programs, and other community resources were also common, although participants described similar limitations in accessibility and availability of needed services.

Effectiveness of Combined Interventions

In addition to describing current practices, participants were asked to share successes they have seen within their agencies in supporting women-identified clients experiencing concurrent DV and problematic SU. This section highlights the successes of combined programming related to both structural-level agency shifts and practices, as well as client experiences.

Agency Successes

At a structural level, the most noted success among participants was the ability of their agencies to successfully shift policies and practice towards a harm reduction model which reduced barriers and promoted client safety and goal attainment. For example, one participant shared,

I think more at a higher agency level, just the fact that we were able to create a position focused on addictions work. That isn't something that we've just always had in the history of our agency. But again, seeing the trend show that we're serving more and more people living with addictions or mental health, we were able to secure the funding to create [the harm reduction] position. (Participant 7, 36:37)

At a staffing level, a key success noted my participants was the reduction in stigma surrounding SU among staff as a result of agency strategies and training. Participants described that by reducing stigma among staff, staff became better equipped and competent to support clients experiencing SU challenges. One participant shared,

So, I'd say one of the biggest ones, that's a little bit harder to measure, is just that stigma reduction and people being comfortable talking about substance use and supporting people with substance use. And we never expected people to be sober, but I think we now know how to work with people who aren't sober a lot better. And to be able to see some of those measures of success because they look different. (Participant 9, 14:12)

One participant reflected on the impact of reduced stigma and increased competencies among staff on a previous client's experience accessing services,

She's just done incredibly well. And, I mean, I would never say that [agency] was all the reason, but I think the fact that we were able to support her better in her addiction and how that was being managed. And not have her feel penalized when she would go out to use, she always felt like she could come back. (Participant 4, 32:25)

Client Successes

At a client level, half of the participants shared examples of clients' exiting DV relationships and/or becoming abstinent from SU as major successes, crediting agency practice shifts and the ability of staff to build honest, authentic relationships with clients as key to these successes. For example, one participant shared,

> *She successfully completed our program. She stayed on suboxone. She stayed sober. She was then able to move forward with crisis counseling and trauma counseling. And to this day, she's still sober . . . For our team and our understanding of harm reduction and a supportive approach, focusing on women being on their healing journey, and understanding her healing journey as a victim of domestic violence, recognizing she needs to become stable with her substance use in her eyes.*
>
> (Participant 1, 16:33)

In addition to this, an important theme that arose when discussing client successes was that success often looks different for each client and does not always involve abstinence or exiting a DV relationship. Non-abstinence related successes included increased engagement in services, clients not being discharged from programming due to SU, promotion of client safety, and increased connections to formal supports. One participant shared their opinion on non-abstinence related client successes,

> *I think it's little things that aren't little things. Like if they have visitations with kids, that they're getting visits more often. A lot of it is just that they've made an appointment, right? When people are in active addiction, just getting to anything, like getting out of bed, sticking in one place for a time can be really, really hard. So just making those little appointments or getting set up with a new support, regardless of if*

they're only seeing that support 50% of the time that they're scheduled to. Or going to get set up on suboxone or methadone. And even if they fall off right away, they've at least been to the clinic, they know what it's like, they've been to the pharmacy. (Participant 9, 15:46)

Another participant added,

But, like I said, success doesn't always mean they stop using. It means that we just help them find something else, whether that's another location, whether they get housing or they find their own place. And to me, when they can move into something out of shelter, and we're not asking them to leave, that's more of a success. (Participant 8, 35:26)

In both of the above examples, participants noted having specific addiction/harm reduction staff positions as a key factor in promoting these successes. Another participant shared a client success related to the safety of children,

I think success is, we have had one case where there's a kid involved. And so, child services are also involved. But it hasn't been an immediate apprehension of the child with mom using . . . we worked with the mom to have a safety plan which included not having her kid in the unit if she's using, not bringing her child to do pickups with her, or if she's going to be using in the community, arranging for alternative childcare, and regular check-ins as well. And letting staff know where the kiddo was, who the kiddo was with, and just being in contact if she needed anything, and when she would be coming back. And that was okay with child services. And honestly like that's a frigging win these days. (Participant 6, 13:20)

Another key benefit and success of emphasizing authentic relationships with clients was the ability to promote compassion and honesty even in cases where SU needs exceeded agency capacity to ensure safety. One participant shared their experience in discharging a client from services due to SU needs that exceeded agency capacity:

> *some of our staff were worried because it feels icky. But when she left, she gave us all a hug, and she said thank you. I think there's just so much grace in being honest with people, you know, like skirting around the issue is just so disrespectful. These people are living this life they know, so shedding light on that in a kind and compassionate way and making space and slowing it down.* (Participant 5, 42:04).

Another participant echoed this experience of discharging a client,

> *And then it's that little blip of knowing that they're being heard, they're being supported. Like it doesn't matter, even though she was very, very angry with us at the end because some things happened that she just wasn't physically safe in the shelter for some health needs, but for her it was that "okay, I can do this."* (Participant 8, 32:36)

When discussing successes, it is also important to note that goals and success may look different dependent on the services offered at each agency. For example, in an emergency shelter setting where the intention is to promote immediate safety and stabilization, clients staying in one place and not being discharged from shelter for using substances may be seen as key successes. For example,

> *I will say, what we're really providing is just a few days of getting someone off the street, having some food, sleeping in a warm bed for a little bit, and oftentimes that's the extent of it. But they always come back, too. So, I mean, that just tells me that*

they're feeling welcomed, and that there's not a stigma around their addiction. (Participant 4, 25:01)

One participant noted the challenges in measuring success in short-term settings,

> *Yeah, well, success, it's always a challenge to measure in an emergency setting. And we do serve a function, and the more people we can assist, the better. And that does mean shorter times of stay in most cases, in order to continue to address who's sitting on a wait list, or the calls that are coming in on a daily basis.* (Participant 2, 43:27)

Alternately, some participants described the benefit of agencies that offer long-term, consistent supports, such as community-based outreach programs, that address personalized recovery goals,

> *And then we see a lot where it's really complex. And it's really slow going where people are going back to their partners and then they're coming back and getting support, and then they're going to treatment. And it's like, this has been going on for 3 years, which is what we see all the time with addiction . . . So just having that really long-term support - we have people that have been working with some of the women for like 3 years, like the same worker and the same client for 3 years. Being at least one solid support that's going to be there throughout the entire thing, for when they're doing really good, and when they're not and they really need those services.* (Participant 9, 22:25)

Another participant, whose agency provides long-term transitional housing spoke to the impact of stable housing in supporting long-term healing,

> *we were able to keep people housed and provide support, with most families staying longer than a year. That speaks to, again when we are low barrier, we are able to*

keep women housed more. And I think that's ultimately our main goal because, when women are housed, then we can really work on healing and safety and all of that. (Participant 3, 38:05)

Barriers to Effective Combined Interventions

In addition to program successes, participants shared similar barriers to effectively implementing harm reduction practices and shifting towards combined DV/SU programming. This included barriers related to stigma and misconceptions about DV and SU as well as barriers imposed by limited agency capacity and funding, including the impacts of capacity limitations on client safety and geographically isolated communities. This section also describes the challenges of providing combined services within prescribed agency mandates.

Stigma & Misconceptions About SU and Harm Reduction

Stigma and misconceptions about SU and harm reduction, as held by agency staff, clients, the broader community, government, and funders, was noted as a significant barrier to implementing effective combined programming. For some agencies, the shift from abstinence-based models to ones focused on harm reduction was a challenge for previously existing staff whose training had been informed by abstinence-based approaches. As one participant described,

Some people who maybe had been here a while, it maybe took longer to adjust to some of the concepts and adjust to the fact that no, we're not just going to kick women out because they had booze in their room, or evict women because they came back high or because they almost overdosed, even. We're going to try and wrap supports around them first. (Participant 2, 26:42)

Participants described stigma and misconceptions among staff as informing views about staff and client safety related to client SU which impacted the ability of the agency to influence meaningful change towards combined interventions. One participant described the differing perspectives among staff,

> *We have certain staff who were like, "absolutely, it's not safe for us to have people who are using in shelter." And then we had staff who were like, "what are you talking about? That has nothing to do with safety." And that depends on lots of things – experience, belief about certain things, exposure, whatever."* (Participant 5, 28:20)

One participant noted the implications for clients when frontline staff hold stigmatizing beliefs and are reluctant to adopt harm reduction strategies,

> *And you can do a lot from policy and practices, say, even a shelter implementing harm reduction. They maybe change some policies and practices. They do some training, things like that. But if we have the two people working in the shelter on the front line, and they haven't actually adopted that harm reduction, then that's not going to actually get to the people that it needs to get to.* (Participant 9, 50:06)

Alternatively, other participants shared that staff were open to challenging their beliefs about SU and embracing a harm reduction approach to their work within the agency,

> *Since my time here, everyone here has been super accepting of a harm reduction approach, and the board and management are very in support of it.* (Participant 3, 30:29)

Participants also noted self-stigma among clients who use substances, as well as misconceptions held by clients who do not use substances as barriers to offering harm reduction and combined programming fully in their agencies. For example, almost every

participant described a service barrier in which clients who use substances assume that staff hold stigma or misconceptions related to SU, or assume the agency operates from an abstinence-based approach, impacting clients' ability to feel safe enough to openly disclose their level of SU. One participant explained how shame and stigma impact clients' ability to disclose SU,

> *Sometimes it's hard if women feel shame around it, or they may feel that they might not be able to secure shelter space if they use substances. Because of that they might not disclose to you.* (Participant 1, 5:14)

When this occurs, it may be more difficult for staff to provide appropriate support or mitigate potential harms surrounding the clients' SU because the extent or risks of their use are unknown. Participants also described stigma among clients who do not use substances, leading to misinformed perceptions about the safety of agencies employing harm reduction strategies. One participant commented on attempts to address these fears among clients through a harm reduction model,

> *I think something that we have spoken a lot about is how can we present the fact that our shelters are harm reduction based before individuals access shelter so that they're fully aware of what they're getting into. But doing that in a way that isn't going to increase fear and then potentially make women feel like they need to remain in their home . . . So, it's creating that narrative that a) doesn't push people away, but also helps people to understand that they may be coming into seeing individuals under the influence. But that we're going to still do what we need to do to ensure that everyone's safe.* (Participant 8, 25:55)

Participants also described challenges related to stigma and misconceptions within their communities and provinces, impacting public support and potential funding for harm reduction and combined programming within DV agencies. As one participant described,

> *And as [participant 8] mentioned earlier, specific to our area and jurisdiction. We service 3 major cities and then some rural populations. For two of our major cities, the one really embraces substance use more than the other. So, if we were to ever present this in one of our cities, it would be a flat-out no.* (Participant 7, 48:34)

Participants also noted provincial government responses and opinions with respect to SU, DV, and harm reduction as playing a role in both the increase in complex needs and lack of appropriate funding and available supports. For example, participants from select provinces noted lack of government support and funding for supervised consumption sites as both contributing to unmet needs in their communities and as evidence for the lack of support for harm reduction strategies. One participant described,

> *I believe there needs to be a lot of change to support those with substance use, domestic violence, mental health, all together. All of our supervised consumptions sites in [province] are not funded by the government, so I believe that in itself kind of shows the government's position on looking at addiction and harm reduction.* (Participant 3, 27:55)

Limited Capacity & Funding

Influenced in part by stigma and misconceptions about DV, SU, and harm reduction, participants consistently noted lack of appropriate funding as contributing to capacity limitations within their agencies. As one participant described,

It just comes down to the funding. The standard, from my understanding, from the [provincial government] is that everyone is supported, and it is the expectation. But then where's the extra support? Because we can't be doing this fully if there's no greater support. (Participant 8, 50:01)

Another participant, in reflecting on how current program limitations could be improved, answered,

I'm imagining all these magical funds that we are receiving to be able to support our clients like that. Financial funding and fundraising and support is a huge barrier to being able to do that because, there are still times where we are single staffed, for example. (Participant 1, 32:36)

Another participant shared a similar sentiment,

ultimately, we see the need as frontline workers. We see what the women need, but there is that lack of funding and money to do it. And I think that's the biggest barrier and what needs to change. (Participant 3, 29:56)

Safety

The most significant program barrier to implementing harm reduction and incorporating combined interventions, imposed by limited agency capacity and funding, was the ability to ensure the safety of clients accessing services. Every participant described the most significant challenge in employing harm reduction practices and policies as being the ability to ensure the safety of children in shelter when SU is present. As one participant described,

I think a big one that I know is very common in the VAW sector is the children. Like how do we potentially have a space where individuals can store their substances

while we have children in shelter. That just becomes a greater concern for some staff. There's a lot of fear based around that, and a lot of fear from moms. (Participant 8, 24:26)

This concern was especially apparent in shelter programs which involved aspects of communal living (i.e. shared bathrooms, kitchen, living spaces), as is the case in most emergency DV shelters. As one participant described,

There is that fine line because we are family shelter. There are children in the shelter. For an example we found used needles in a garbage in a bathroom before . . . There is now a safety risk someone is going to go pick up that garbage and then now they've been pricked by a needle, which is why we have such specific policies around substance use in the shelter. (Participant 1, 21:05)

Limitations imposed by single staffing, lack of medical staff on site, and lack of infrastructure to support monitored safe use on site were also commonly cited concerns related to ensuring the safety of clients who are using substances. As this participant explained,

And as a single staffed person who has a full house of 18 plus people, it is very difficult to be able to make sure that that person that's withdrawing in that room is okay. That is a big responsibility for one person when they might already have 3 other women in crisis, and they might be bringing in an intake, or on a crisis call, etc. That's a very hard expectation to meet. (Participant 1, 32:57)

Another participant further described the challenges in balancing the safety needs of all clients,

How do we support everybody because everybody has very different needs? And there can be a lot of trauma being around substance use or people who are yelling, right? So, for somebody who's coming out of domestic violence, maybe their partner used to yell and scream and be unsafe when they're using substances. But we also have to support somebody who is yelling and screaming and using substances. And how do we do that? (Participant 9, 41:14)

Geographically Isolated Communities

Some capacity related barriers arose as unique to two participants from small, geographically-isolated communities. These barriers included lack of available people in the community to fill long standing staff vacancies and cases where clients were transported to nearby communities as needed services were not readily accessible or available locally. A different participant from an urban center commented on their understanding of the limited capacity of isolated communities in their province,

One of my managers recently attended a training event and she reported back to me that lots of the shelters in the northern part of [province], like in the rural areas, they just don't have the capacity really to have that harm reduction approach or tolerate substance use there. (Participant 3, 35:53)

Agency Mandates

Related to balancing client needs, half of participants also described challenges supporting clients within the prescribed mandate of their agencies as offering DV services. For example, in cases where a client's pressing needs were related to SU, even though DV may be a contributing factor, because participant agencies are mandated and funded to

provide DV supports, clients may not fit the intended purpose of programming at that time. As one participant explained,

> *there is a huge intersection between addiction and domestic violence in that that's never going to be a clean break. You have to service the two at the same time. So how can we do our best while also maintaining our scope of practice? Because, truly, there may be some folks so heavily into their substance use or addiction that they're not quite ready for us.* (Participant 7, 9:50)

Another participant echoed,

> *As a transition house, we are really moving away from the mandate that we originally had and moving into areas that we're just not trained for. We have folks coming in with really serious mental health and addictions and that's just not what we're doing. And of course, there's trauma in there, most of those women come from traumatic backgrounds and violent backgrounds.* (Participant 4, 15:43)

This participant additionally added that the need to stay within their mandate for services is tied to their source of funding, with prescribed lengths of stay in shelter set by funders,

> *And so, our mandate is that a typical stay doesn't exceed 30 days. Depending on the severity of the addiction, there are circumstances or situations where we do determine that it's not an appropriate fit for a person. If they're having to use every day, and it's interfering with their ability to do the other work that needs to happen to move out of our emergency transition house into something more permanent, then we do look at that and say, "this isn't the right fit right now."* (Participant 4, 5:34)

As described in the literature review (Armstrong et al., 2019), some participants noted a trend in violence against women (VAW) agencies shifting towards broader mandates in order to account for these changing client needs. As one participant described,

> *The languaging was really opened up for agencies that wanted to expand services. It really opened up the ability to do that, because the language went from "women and children experiencing domestic violence" to "women and children who are at risk of experiencing violence," which could be anybody.* (Participant 4, 11:30)

Another participant commented on discourse surrounding this trend to shift mandates,

> *So how do we flex? How do we meet the needs of as many people as we can? There's all this language around mandate shift and I just don't see it that way. If our mandate is, "we're a feminist organization and we are committed to supporting women and children fleeing violence or gender-based violence." I mean, that's a pretty wide mandate.* (Participant 5, 1:02:08)

Recommendations

This final section outlines the opinions of individual participants regarding how current services and noted barriers can be improved to better support the needs of women experiencing DV and problematic SU. The chapter concludes by presenting participant opinions on ideal service models for this population.

Addressing Barriers & Limitations

As presented in the previous section, participants consistently noted similar barriers to meeting client needs and fully implementing SU supports in their agencies including stigma, limited agency capacity, and restrictive agency mandates. In exploring present challenges, participants were asked to share recommendations for addressing noted barriers

and improving current services. One of the most common recommendations among participants was prioritizing continued education and training for staff related to harm reduction, problematic SU, and the connection between DV and SU to challenge stigma and further improve staff competencies. For example, one participant explained,

> *I think education is really important and just continuing to have those trainings on substance use and naloxone and Narcan is just really important. I think as we continue to get new staff, also just having that awareness of harm reduction I think is really important.* (Participant 3, 20:08)

Staff training was noted as playing a significant role in shifting the agency and staff towards a harm reduction model, as well as in reducing stigma, calming fears about responding to overdoses, and increasing staff competencies. One participant described,

> *I have created a PowerPoint presentation that I do, currently just with new staff, which I've reworked a little bit based off of what we're hearing. I'm hearing from staff what they want, but it's a basic understanding of addiction, substance use, the interconnection of DV and substance use. And then I also do an overdose response training and naloxone training . . . It has been challenging, as any change is, to have everyone really get there. But we're slowly getting there. And it's always conversations. It's always advocacy, challenging some perspectives or conversations.* (Participant 8, 42:35)

Another participant described the importance of consistent conversations about SU and harm reduction across the agency to decrease stigma,

> *...before you would have some staff that say "yeah, we're harm reduction," but don't know what that means. And some staff say "no, we're not harm reduction." But we*

finally sat down and committed to saying we work from a harm reduction lens . . . It's a pretty consistent conversation and I think it's helping to decrease that stigma. (Participant 7, 17:50)

Another commonly noted recommendation was increasing agency capacity to provide more extensive supports related to SU. For the three agencies which did not currently have an addiction/harm reduction staff role, the development of such a role was a main recommendation for increasing agency capacity. Additionally, when asked about their recommendations for improving presently available services, one participant explained,

When I think about best case scenario, it's just people having the capacity to deal with all of the nuance that is domestic violence and substance use in the same facility and not trying to separate those two things. Having the capacity with workers, having the capacity for the actual building, having capacity with staff and funding. I think it has to be like all in. And then, knowing that, potentially, it's never going to be perfect either. And then when it's not perfect, how are we still supporting people? (Participant 9, 46:43)

In terms of improving capacity, participants specifically described a desire for increased capacity to offer medical care, such as infrastructure to accommodate safe use on site and having medical staff, including nurses, available. For example,

if we could have a safe injection site on site, and again, that would have to be very fast forwarded down the road. But to break down that barrier of women needing to go somewhere to use safely, to be able to go somewhere to store safely, if we could have the proper infrastructure in place so that they can use safely on site and safely store things on site. (Participant 7, 46:44)

Being able to improve existing infrastructure in these ways was also believed to reduce safety concerns related to children being exposed to SU by promoting separation in the spaces where SU is and is not occurring, as well as ensuring that substances and safe use supplies are more safely stored and disposed of.

One of the biggest challenges to increasing agency capacity in this way, as described in the previous section, is the need for additional funding. Further highlighting this, when participants were asked to share their opinions on the level at which the most change needs to occur to work towards ideal service models (i.e. government, societal views, agency structure/policy, frontline staff attitudes, etc.), all but one participant shared an opinion that the most change needs to occur at a government and societal level. These participants expressed a belief that if advocacy efforts could help reduce stigma related to DV and SU, harm reduction would be further accepted and funding would likely increase, improving the ability of agencies to meet client needs. One participant explained,

> *Having outside agencies, the public, and the government understand that more support is needed in shelters to support these women is crucial because if that support is not offered, then who is offering that support? . . . Where are women expected to go when there's not that umbrella of support around them where they can be successful in programs?* (Participant 1, 46:54)

One participant acknowledged that, while structural shifts are necessary, emphasis needs to be placed on continued efforts at a frontline, staff perspective level,

> *I think 2 years ago my answer would have been a lot different. I think I would have gone a lot more top down because that's what my education was . . . I think a lot more attention needs to be on that ground level, of the people that we support and then*

those frontline workers as well. Because we can do a lot from the top, but if one worker is like "well, I know that last time they were really difficult to deal with, so, we're not going to let them in" or one manager makes that decision, then it doesn't matter what's happening at the top. (Participant 9, 49:38)

Ideal Service Model

Participants were also asked to describe an ideal service model for supporting clients with co-occurring DV and SU, whether within the capabilities of their agency or not. Responses differed. This finding is unsurprising given differences in geographical and political contexts, current agency capacity and available services, as well as differences in community sizes across participants. Three participants expressed the opinion that having a DV shelter for clients with active SU separate from their current shelter for families would be most ideal to meet individual client needs and ensure everyone's safety. One participant explained their rationale for this recommendation,

It just would be a place where we could direct and target the needs of women who are actively using and don't have children in their care at the time. So, then we would be able to have things like, maybe we could have safe use on the property. Supervised use on property, possibly. (Participant 2, 35:33)

Another participant echoed this, stating,

I'm not sure how this would work for families, but single women who are struggling with addiction and violence. To have almost more of a house parent model where they have staff in those homes, but we aren't worried about them disrupting little kids in the middle of the night. There's a bit more latitude with their safety and it's staffed. I'd

like to get to a place where they could potentially use substances safely, whether it's on site or there's another safe place for them to go. (Participant 5, 47:31)

Conversely, a full separation of services was not supported by others. Participant 9, whose agency presently runs separate shelters for women experiencing DV and homelessness, stated,

But we already kind of have domestic violence, and then, homelessness and substance use separated, and that doesn't work. Because then we are picking and choosing what we're offering services for and then we start to have shelters that aren't high or low barrier. So, I think that is a lot of what we've been seeing when we're trying to separate too much, that we're just putting up more barriers. (Participant 9, 46:49)

These concerns were echoed by another participant who stated,

I'm not a fan of segregation. I would love people to be able to live together in the same community while maintaining everyone's safety. Because if you segregate people, then that's going to still enhance the stigma and really just feed it, and I don't want to do that. (Participant 7, 17:31)

Three of the participants envisioned building capacity to support differing client needs in one space as an ideal model, though two described needing some level of separation (i.e. different programming, separate spaces for safe use on site, etc.) as ideal to meet needs and ensure safety. One participant described the rationale for this recommendation,

you can't have the same expectations of a woman coming in who doesn't struggle with substance use to a woman who does come in struggling with substance use. Those are two different experiences that those people are having, and it's difficult to find that

middle ground barrier where you can say, okay, these rules will work for both people because that doesn't exist, It's not feasible. (Participant 1, 28:56)

The three participants whose agencies did not already have a specified harm reduction/addiction staff role/program described the development of such a role/program as an aspect of an ideal service model. Additionally, one participant's response related to an ideal service model focused on partnerships with external agencies to bridge DV and SU services as an ideal approach, noting the following concerns,

I'm divided on it. Some days I think it would be super helpful to have everything in house and then on other days, I think about like building capacity. And if we are everything to everyone at all times, are we actually doing any one piece of it extremely well? And are we setting people up for success or failure when we reintegrate them back into community? . . . The reality is other agencies don't operate that way. (Participant 6, 31:52)

Another participant described the opposite – envisioning a DV treatment centre that could support all of a family's needs in one place:

It would be lovely to see almost like an IPV treatment center where a woman and her children could go. Where it would be funded so she doesn't have to worry about, how is this being paid for? How do I support my family while we're here? And really just something where the children have access to support services, because we know that children who have experienced violence in the home are impacted by that. And so just that wraparound service for the family. (Participant 4, 40:29)

Only one participant described their current service model as ideal, with only minimal suggestions for further improvement. The current model of this agency provided long-term

accommodations to families fleeing DV, housed a specific harm reduction staff role, offered regular group and individual programming, and was the only participant who did not describe any formal policies around SU on agency property. Long-term programming was also described as having increased capacity to support clients' long-term healing and recovery goals; a key success described by this participant. The only recommendation noted by this participant was increasing capacity to offer staff on site 24/7, as funding limitations presently limit the ability to offer overnight support. This recommendation is not applicable to most emergency shelters as 24/7 staffing is already an integrated part of services.

Regardless of opinions on the structure of an ideal model, every participant stressed the importance of building authentic, transparent relationships with clients from trauma-informed, client-centred approaches as an essential element of an ideal service model. One participant stressed this point,

> *...ensuring that residents are being cared for from a trauma-informed, evidence-based, and harm reduction model will allow for much greater success for recovery and relapse prevention.* (Participant 3, 14:23)

Another participant described the imperativeness of compassion and respect in promoting meaningful change with clients,

> *So, when we are able to actually hold space for them, and actually understand that things are really messy, and we're still going to be there, and we're still going to show up for them, they're still allowed to stay there if they're using, then that's going build that trust. And then we can actually get somewhere after that.* (Participant 9, 28:02)

To further sum up this point, Participant 5 added,

> *I think just, for me, the answers aren't hard. They're probably hard to put into place, but they're very simple. Like "how do we do our work in a way that treats people like people, like humans with desires, and interests, and intelligence, and all of that stuff?" It just is so simple. But how do we get our system to shift to that?* (Participant 5, 1:05:07)

As becomes evident, participants agree that an ideal service model is one that understands and addresses the interconnection of DV and problematic SU holistically, understanding that client experiences and needs are going to be nuanced. Ideal service models were described as requiring commitment from all levels of the agency, as well as flexibility in policy and practice to ensure practices are guided by client-centered, trauma-informed, and harm reduction approaches.

Discussion & Conclusion

Discussion

This qualitative study provides, to the researcher's knowledge, the first Canadian study describing the strengths and barriers of combined DV/SU programming among community-based agencies from the perspectives of service providers. Findings of the present study describe the influence of increased community needs and available research knowledge on the interconnection of DV and SU as contributing to significant shifts in service delivery towards combined DV/SU programming. Participant agencies had varying experiences in developing and implementing these changes to programming. However, these policies and practices were consistently guided by trauma-informed, client-centered, and harm reduction approaches. Study findings particularly highlight the importance of prioritizing transparent, authentic relationships with clients to promote successful program outcomes. The qualitative nature of present study allowed for exploration of meaningful, yet varied measures of program and client successes including client safety, connection to services, and reduced program access barriers, in addition to client recovery and exit from DV situations. Agencies reported experiencing similar barriers to implementing harm reduction and combined interventions, including stigma related to both DV and SU, capacity and funding limitations, and providing combined programming within narrow agency mandates. The study also provided tangible recommendations for future service delivery, including varied opinions on an ideal service model to address co-occurring DV and problematic SU. This section outlines the ways that present study findings align, diverge, and build upon previous literature identified within the literature review chapter.

Context of Shifting Service Delivery

As discussed through the previous chapters, there have been numerous shifts in service delivery across DV and SU sectors in recent years towards combined interventions for addressing co-occurring DV and problematic SU. The motivations to shift service delivery in this direction, including increased awareness of co-occurring challenges (Fernandez-Montalvo et al., 2017; Gezinski et al., 2021; Gilbert et al., 2015; Hovey et al., 2020; Humphreys et al., 2021; Mason et al., 2017; Morrison et al., 2022; Motz et al., 2019; Myers et al., 2015; Rothman et al., 2018; Stone et al., 2021, 2023; Weaver et al., 2015) and seeing the limitations of siloed approaches (Hill et al., 2022; Macy et al., 2013; Phillips et al., 2021; Stone et al., 2021), are aligned across previous literature and study participants. Where the present study diverges from previous literature is through the reports of unanticipated increases in complex, concurrent needs in participants' communities as the major motivator to implementing combined programming. While there was some mention of the worsening toxic drug crisis in the U.S. as a motivator towards changes in service delivery in past studies (Rothman et al., 2018; Stone et al., 2021, 2023), present study findings uniquely describe the impact of the COVID-19 pandemic on community needs and service provision. Participants specifically noted a stark increase in complex needs, demands on their agencies, and capacity challenges since the onset of the pandemic. As previously discussed, none of the studies identified in the literature review made any mention of the impact of the pandemic, largely due to dates of publication prior to 2020.

Study participants additionally noted critiques of provincial government responses and opinions on SU and harm reduction as both contributing to the influx of complex needs as well as the lack of resources and funding to provide appropriate, specialized supports.

Some participants noted that many DV agencies no longer have the option to provide abstinence-based services because of the high rates of SU in their communities. This is an important contribution of the present study, as it highlights the pressure that many DV agencies in Canada are under to adjust to new client needs, often without additional funding and resources to do so. This finding highlights new considerations for the changing landscape of service delivery as a result of an unanticipated increase in complex, concurrent client needs.

Current Approaches to Combined Programming

In responding to this increase in needs, service provision has begun to shift towards combined programming to address co-occurring DV and problematic SU. Previous studies on combined interventions, as identified in the literature review, tended to focus on either the rates of the implementation across geographical contexts or measures of program success. As the present study interviewed participants on practices within their individual agencies, rates of implementation across geographical areas were not explored. What was instead explored in detail were the current theoretical approaches, policies, programs, successes, and barriers of participants' agencies. This specific focus of the present study built upon general recommendations in previous literature (Mason & O'Rinn, 2014) to contribute specific, readily applicable features of successful programming to inform future service delivery in this area. This is especially important given the unique pressures DV agencies in Canada are under following the onset of the pandemic.

Multiple studies within the preliminary review support an argument for trauma-informed care as a potential bridge between DV and SU sectors (Armstrong, 2022; Bennett & O'Brien, 2010; Fowler & Faulkner, 2011; Bennett & O'Brien, 2010; Hertz et al., 2005;

Mason & O'Rinn, 2014). These findings are aligned with those of the present study as participants consistently described the importance of trauma-informed approaches in contributing to the success of combined interventions. Study participants also emphasized the importance of client-centered approaches to practice in contributing to program success. Study participants specifically emphasized the importance of transparency, honesty, and building authentic relationships with clients. The importance of a client-centered approach to practice was only emphasized by one study in the literature review (Motz et al., 2019) and was the only study to provide details into specific aspects of programming that contributed to the success of its combined DV/SU program.

Previous literature (Hovey et al., 2020; Hovey & Scott, 2019; Morton et al., 2015; Nnawulezi et al., 2018) and study participants similarly described the importance of incorporating harm reduction approaches into DV settings. The present study further builds upon arguments for harm reduction by emphasizing the particular importance of specific SU programming and staff roles which extend past changes to general practice and procedure. The benefits of specified SU programming and staff roles within DV agencies include increased capacity, ability to promote client trust and safety, and an ability to offer specialized care. Participants whose agencies did not house specified staff roles dedicated to SU/harm reduction recommended the development of such roles as an element of an ideal service model.

One consistent finding among study participants, which is similar to past literature on DV shelter settings (Gezinski et al., 2021), was the importance of critiquing and making changes to abstinence-based policies in order to fully incorporate combined interventions. Recommendations for policy changes include addressing strict "zero-tolerance" policies for

SU and limits on allowed lengths of stays (Gezinski et al., 2021), as well as building capacity to address single staffing issues (Hovey et al., 2020). Study participants noted the main consideration for any changes in policy or practice being the promotion of client safety related to both DV and SU. Another important overlap in previous literature and the present study was an emphasis on cross-sector collaboration to bridge DV and SU sectors and as a best practice to meet the needs of clients experiencing both challenges (Dauber et al., 2017, 2019; Holly & Horvath, 2012; Isobe et al., 2020; Mason et al., 2017; Stone et al., 2023; Tandon et al., 2020)

Study participants and previous literature also described commonalities in the limitations and barriers of DV agencies in fully implementing harm reduction and effective combined programming. These barriers include structural barriers (Hovey et al., 2020; Hovey & Scott, 2019; Morton et al., 2015; Nnawulezi et al., 2018), barriers related to staff stigma and misconceptions about either issue (Morrison et al., 2022; Stone et al., 2023), and limitations of providing SU supports within a narrow mandate of the agency (Morton et al., 2015). The most significant barrier noted by study participants, and mentioned in previous literature (Hovey & Scott, 2019), is balancing the safety needs of children in shelter when SU is present. Both study participants and past literature additionally described how stigma about SU often informs safety concerns among staff, limiting the ability of agencies to fully engage in this work (Gezinski et al., 2021; Hovey et al., 2020; Hovey & Scott, 2019; Morton et al., 2015). Study participants noted ongoing training, staff development, and collaborative conversations to challenge staff misconceptions as key in addressing stigma and improving staff competencies.

Studies on incorporating DV supports into SU treatment settings were less applicable to study findings as all study participants were employed and spoke to their experiences within DV or generally defined support agencies and not SU treatment settings. However, similar barriers to implementing combined interventions into SU treatment settings were noted including limited funding, agency capacity (Cohn & Najavits, 2014; Morrison et al., 2022), SU practitioner misconceptions about DV (Hill et al., 2022), and mandate restrictions (Motz et al., 2019).

Effectiveness of Combined Programming

The majority of the studies in the literature review focused on exploring the effectiveness of combined programming to address co-occurring DV and problematic SU. These studies consistently evidenced that combined interventions for this population are effective and address the limitations of previously siloed approaches. What differed across these studies was how success was measured. For instance, studies exploring the effectiveness of incorporating DV supports within SU service settings focused on abstinence (Gilbert et al., 2015, 2023), program engagement (Myers et al., 2015), and posttraumatic growth (Edwards et al., 2022) as a measures of program success. Alternately, studies which focused on harm reduction in DV settings focused on promoting empathetic and non-judgemental responses from staff (Nnawulezi et al., 2018), reducing barriers to services, and promoting self determination (Hovey & Scott, 2019; Nnawulezi et al., 2018) as measures of success.

While quantitative measures of success were not used in the present study, participants described numerous areas of program success which aligned with the measures of success noted above. Specifically, participants described agency-level successes including

successfully shifting policy and practice towards harm reduction and incorporating SU programming and practitioner-level successes including decreased stigma and increased competencies related to SU. Participants also noted client-level successes including promoting client safety, self-determination, engagement in programming, exiting DV, and, in some cases, abstinence from substances. Importantly, study participants emphasized that abstinence is not the only goal in harm reduction and that client successes from a harm reduction perspective are much more nuanced and client led. What becomes evident from both previous literature and study findings is that multiple measures of success can be used to explore the effectiveness of combined interventions and attention should be paid in research efforts to determine specifically what measures of success should be explored.

Another important contribution of the present study is that it explored specific aspects of program design and implementation which were viewed as contributing to these important successes. Most commonly, participants credited the ability of their agencies to shift all levels of practice towards harm reduction models, incorporating specific SU supports and programming, and taking client-centered approaches to practice as contributing to program success. Only one study identified in the literature review explored in detail the specific elements of programming credited to program success (Motz et al., 2019). Similar to study findings, these elements included the ability to offer DV and SU services within a single program, prioritizing the therapeutic relationship, and promoting safety and self-regulation (Motz et al., 2019).

One finding relevant to future research efforts, reflected by both study participants and previous literature (Hertz et al., 2005), is that applicable measures and contributors of client success can vary dependent on the type of services that agencies offer. For example,

immediate safety, stability, and clients moving on from services voluntarily (as opposed to being discharged due to SU) were noted as measures of success among study participants who practiced in emergency shelter settings. Among participants whose agencies offered longer term housing and/or outreach services, client successes were more commonly cited as clients securing long term housing and safety and reaching SU related goals, such as abstinence or attending treatment. This finding is significant as it highlights an important consideration for measuring program success in future research on combined interventions.

Recommendations

A number of studies in the literature review emphasized a recommendation for holistic, combined programming that is intentionally designed to address the co-occurrence of DV and problematic SU (Edmond et al., 2014; Edwards et al., 2022; Hill et al., 2022; Isobe et al., 2020; Morrison et al., 2022; Short et al., 2019). Interestingly, these studies made limited mention to the importance of employing a harm reduction approach to successful combined interventions. Alternatively, previous studies on DV shelter settings offered strong recommendations for harm reduction in DV service settings, though made limited mention of the importance of implementing specific combined DV/SU programming (Hovey et al., 2020; Hovey & Scott, 2019; Morton et al., 2015; Nnawulezi et al., 2018). Findings of the present study are significant as they bridge the practice recommendations of past literature, emphasizing both the importance of employing combined DV/SU programming as well as ensuring combined interventions are grounded in harm reduction approaches.

Other specific practice recommendations towards combined interventions, described by study participants and past literature, include structural agency changes (Gilbert et al., 2023), intentional actions that align practices and policies across all levels of individual

agencies (Hovey et al., 2020), increased collaboration within agencies (Dauber et al., 2017) and across DV and SU sectors (Gezinski et al., 2021; Stone et al., 2021), increased staff training (Cohn & Najavits, 2014; Gezinski et al., 2021; Phillips et al., 2021; Stone et al., 2021) and a need for additional resources and funding to increase available programming (Cohn & Najavits, 2014; Gezinski et al., 2021).

Despite consistencies in recommendations to improve services, as presented in the previous chapter, study participants had varying opinions on the structure of an ideal service model to address co-occurring DV and problematic SU. Regardless of differences in program structure, it becomes resoundingly clear from participant interviews and previous literature that an ideal service model for addressing DV and problematic SU is one that is trauma-informed, client-centered, and grounded in harm reduction approaches. Emphasis should be placed on the therapeutic relationship, including engaging clients with honesty, authenticity, and compassion.

Limitations & Delimitations

The researcher took steps throughout the research process to ensure that the present study was rigorous and as readily applicable to practice as possible. However, there were notable limitations of the study related to the representation and generalizability of findings. This section describes these limitations and delimitations.

Representation

The researcher intentionally decided to focus the present study on professionals working in organizations serving women-identified survivors of DV. This was determined due to women experiencing the highest rates and severity of DV (Mason et al., 2017), as well as DV organizations historically being mandated and designed to serve women-identified

survivors (Armstrong et al., 2019). However, the researcher acknowledges that this decision limits the representation of DV survivors of other genders. An additional delimitation of the study was its focus on adult survivors, though service provision could also include services for dependent children of adult clients. The researcher believes there could be much to gain from specifically studying the needs and service experiences of dependent children, especially considering that the safety needs of children was the most noted barrier among participants to fully incorporating harm reduction approaches at their agencies. However, studying these experiences was outside the scope and capacity of the present study.

The researcher also intentionally decided to study combined programming within community-based organizations, which limited the inclusion of government-run and private SU facilities. The researcher believes this decision, in part, contributed to participant recruitment of practitioners solely from DV and generally defined agencies and no recruitment of participants from SU treatment facilities. This limited the ability of the research to compare approaches, policies, and practices across different sectors, however, was an intentional decision due to an aim to explore combined programming within front-line, non-profit community organizations.

Generalizability

Another important limitation of the present study is the implications of challenges experienced in participant recruitment, as described within the methods chapter. While past literature describes that service delivery in this area was only recently emerging (Isobe et al., 2020), the researcher did not anticipate challenges in identifying 8-10 such agencies across Canada. One interesting finding from participant interviews, which highlights the implications of this on study findings, was the discovery that study participants held limited

knowledge of other agencies in their communities engaged in combined programming. Of particular significance, both participants who were engaged in a national community of practice, and whose agencies housed specific harm reduction/addiction staff roles, noted that, in comparison to other agencies in the community of practice, their services fell "somewhere in the middle" in terms of extensiveness and progressiveness. However, these participants were unable to name agencies with more progressive or established programming and the researcher was unable to locate these agencies, despite connecting to the coordinator of the community of practice. This disclosure from these two participants suggests that there is more to know, and that more established services may exist that were not reflected in the present study. Given this, it can be considered a limitation of the present study that further established services may exist but were not reflected in study findings.

Additionally, while the researcher acknowledges that all cannot be known about a particular research topic (Thorne, 2016), the generalizability of findings to reflect a Canadian context is further limited as only four provinces – British Columbia, Alberta, Saskatchewan, and Ontario – were represented. The researcher considers the possibility that identifying prospective participants in other provinces was unsuccessful as none, or very few, existed, however the researcher cannot confirm this. Either way, in acknowledging the unique histories of social policy development and implementation across Canadian provinces (Boychuk, 1998), it is a limitation of the present study that the perspectives of practitioners in other provinces were not included.

Colonialism

While limitations due to challenges in participant recruitment are described, it is particularly important to discuss the specific implications of the lack of inclusion of

practitioners from the territories in the present study. Despite efforts towards multi-frame sampling to identify agencies in the territories and geographically isolated communities where services may be limited, the researcher was unable to identify or get into contact with any such agencies. The implication of this is that the present study lacks an understanding of the specific service needs of northern women experiencing co-occurring DV and problematic SU. Given the population of the territories is largely Indigenous (Statistics Canada, 2023) and Indigenous women experience lifetime rates of DV at higher rate (61% vs 44%) than non-Indigenous women (Heidinger, 2021), it is a significant limitation of the applicability and generalizability of study findings.

The researcher also acknowledges the limitations of Indigenous perspectives being reflected in the present study, as the study was conducted within a colonial organization utilizing Western research methodologies. While participant interviews did not specifically intend to study Indigenous organizations or populations, three participants did note servicing a high percentage of Indigenous women in their agencies and two of which noted cultural programming as a part of their services. Although the current study explored programming for women survivors generally, which is inclusive of Indigenous women, it is a limitation of the study that the unique needs of Indigenous women are not specifically accounted for.

Strengths

Despite important limitations, there were notable strengths of the present study. Most significantly, study participants offered a wealth of practice knowledge from years and even decades in the field, including an unwavering commitment to supporting survivors at the intersection of DV and SU. It became resoundingly clear through participant interviews that none of the shifts that occurred within participant agencies would have happened without the

dedicated advocacy of practitioners, the ability to challenge long held theoretical approaches and policies, and a commitment to continuous learning and collaboration. Participants demonstrated an openness and vulnerability in interviews to share lessons learned, as well as share their candid opinions and critiques of both their own agency's practices and the larger social systems that impact their work. It was through this open dialogue with participants that interviews provided exemplary insight into the progressive actions of professionals and community-based organizations in challenging the status quo to assure the efficacy of available services. The researcher was moved by the commitment and tirelessness of participants in continuously challenging stigma and barriers in order to move towards exceptional service delivery in this area.

Application to Social Work Practice

There are important, readily applicable recommendations for social work practice gained through this research which can be categorized as either applying to individual professionals engaged in this work or applying to agencies and decision makers. Recommendations for individual practitioners include:

1. Adoption of trauma-informed, client-centered, and harm reduction approaches to practice.
2. An emphasis on developing genuine, authentic relationships with clients which acknowledges the nuances of client experiences and addresses client needs holistically.
3. Engaging in continued ongoing education and professional development to improve competencies related to DV and SU, including an emphasis on understanding and addressing their co-occurrence.

4. Continuing to think critically and challenge historical policies and procedures which uphold stigma and exclusion to services for clients experiencing co-occurring challenges.

At an agency level, recommendations for community-based organizations and management include the following:

1. Ensuring harm reduction approaches are aligned throughout all levels of the agency – frontline staff training and competencies, policies and formal procedures, management, mandate, Board, etc.
2. Reviewing policies and procedures, including use of language, to ensure messaging is informed by non-stigmatizing, harm reduction principles.
3. Providing ongoing training and professional development opportunities on harm reduction, including establishing formalized training procedures for newly onboarded staff.
4. Building partnerships with external SU and other social service agencies to strengthen referrals and collaborative case planning for clients in need of external harm reduction/SU support services.
5. Focus capacity building efforts on the sustainable development of specific addiction/harm reduction programming and staff positions.
6. Focus advocacy and awareness efforts at a community and government level, challenging stigma and misconceptions about SU, including the specific interconnection of DV and SU.
7. Engage in ongoing collaboration and information sharing with DV and other social service agencies within and across Canadian provinces to share resources, successes,

and lessons learned in order to work collaboratively towards effective models of practice.

As described, shifting well-established DV services towards combined interventions to address DV and co-occurring SU requires ongoing efforts from all levels of the agency. Individual practitioners are encouraged to reflect on their own biases and perspectives about DV and SU and engage in ongoing competency building and professional development. Taking steps to ensure that the practice of individual practitioners is grounded in trauma-informed, client-centered, and harm reduction approaches is especially important to promote positive client outcomes. Aligning with an important value of the social work profession, practitioners are also encouraged to challenge stigmatizing and exclusionary policies and practices to ensure that access to services is fair and equitable for clients experiencing co-occurring DV and SU (Canadian Association of Social Workers, 2024).

Management and decision makers at community-based agencies are similarly encouraged to apply harm reduction approaches to align all levels of the agency, including critically analyzing existing policies and procedures to remove stigmatizing language. Building partnerships across agencies and service sectors is also encouraged to challenge stigma, promote education and competency building to bridge DV and SU sectors, and to promote collaborative case planning and referrals.

The researcher acknowledges that applying these principles and developing effective combined interventions undoubtedly requires additional funding and resources, a barrier consistently noted by study participants and previous literature. Following the suggestions of study participants, DV agencies are encouraged to advocate at community and government levels to challenge and reduce stigma, educate on the interconnection of DV and SU, and

describe the importance and efficacy of combined interventions. It was believed by some participants that if government and community perspectives on DV, SU, and their co-occurrence can be further informed and changed, harm reduction and combined interventions may be further prioritized, increasing the support and funding opportunities for agencies engaged in this work.

Questions for Future Research

As became evident through participant interviews, one of the most significant barriers to effective implementation of combined interventions remains stigma and misconceptions about SU, DV, and their interconnection. Participants described stigma among frontline staff as limiting the supportiveness of responses to clients experiencing both challenges, as well as self-stigma among clients, limiting their sense of safety and comfortability within DV agencies. Participants also described stigma at a community and government level as attributing to the lack of funding and financial support agencies receive to implement combined interventions.

As such, an informative area for future research would be studying the ways that stigma related to SU and DV limits the ability of agencies to shift towards combined interventions. This would require study approaches that explore perceptions about both challenges at all levels of community-based agencies including clients, frontline staff, management, directors, and the board of directors. Research in this area would inform potential gaps in knowledge, identify key issues at varying levels of agencies, and determine the level at which further interventions are needed. Research knowledge in this area would be imperative in informing potential training resources, advocacy initiatives, and education

campaigns to increase awareness and understandings of co-occurring DV and SU with the aim of improving the availability and efficacy of combined programming.

Conclusion

As stated within the introduction, the present study aimed to explore promising practices among community-based organizations in providing combined programming to women-identified survivors of DV experiencing co-occurring problematic SU. It was expected that agencies across Canada would be implementing combined programming in different ways and to varying degrees of success, due to potential barriers such as agency capacity, training, funding priorities, and historical mandates. While differences in service delivery due to anticipated barriers was an important part of study findings, the present study most significantly uncovered specific and meaningful elements of successful combined interventions to inform future program development in this area.

The significance of study findings is that insight has been gained into the specific elements and contributors to success of combined DV/SU programming across Canada. By developing a deeper understanding of the theoretical approaches, policies, successes, and barriers of implementing combined DV/SU programming, study findings are intended to be readily applicable to future programming in this area. By identifying innovative practices, the results of this study provide useful evidence to help guide agencies in developing effective combined programming with the intent of improving wellbeing and healing outcomes for women-identified survivors and their children.

By gaining valuable insights from the practice knowledge of dedicated professionals, this study provides a fulsome understanding of the firsthand experiences and perspectives of professionals and agencies engaged in the difficult, yet endlessly important work of bridging

the DV and SU sectors to provide effective combined interventions. This study aimed to provide a starting point for researchers and practitioners to continue improving available services. This study is an effort to combine the insights of practitioner experience and academic research knowledge with the aim of improving support and service delivery for a population deserving of specialized, evidence-based, trauma-informed, and client-centered care.

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Appendices

Appendix A

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Kelowna, BC Canada V1V 1V7
Tel Toll-free: 1 866 596 0767

Combined Programming for Domestic Violence and Substance Use in Canada

Recruitment/Initial Contact Letter

Hello,

My name is Savanna Belitski and I am a Masters of Social Work student at the University of British Columbia – Okanagan pursuing a thesis under the supervision Dr. John Graham. I am conducting research that explores current practices among community-based organizations in serving women identified survivors of domestic violence experiencing co-occurring substance use challenges. Based on your agency's mandate and service provision, I believe you hold expertise that would be valuable to this research.

I will be interviewing approximately 10 professionals from community-based agencies that provide some level of combined services for domestic violence victimization and substance use. Should you agree to participate, you will be interviewed on current practices at your agency in this area, including successes, challenges, and current policies. The interview would be conducted one-on-one over Zoom or in person and is expected to take approximately 1 hour of your time.

If you are interested in participating or would like more information regarding the proposed study, please email me at belitsks@ubc.ca. If you have someone in mind who might be a candidate to participate in this study, please feel free to provide them with the

recruitment letter attached so that they can get in touch with me directly. Thank you very much for your time.

Kind Regards,

Savanna Belitski, BSW, RSW
Graduate Student
School of Social Work
Faculty of Health and Social Development
University of British Columbia – Okanagan Campus

Appendix B

Faculty of Health and Social Development
Okanagan Campus
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Follow Up Recruitment Email

Hello,

I hope this email finds you well. I am following up on the previous email below as a reminder of the pending deadline on [DATE] for expressing interest in the research study exploring combined programming for domestic violence and substance use.

If you are interested in participating and/or would like more information regarding the proposed study, please email me at belitsks@student.ubc.ca. Additionally, if you have someone in mind who might be a candidate to participate in this study, please feel free to provide them with the recruitment letter attached so that they can get in touch with me directly. Thank you very much for your time.

Kind Regards,

Savanna Belitski, BSW, RSW
Graduate Student
School of Social Work
Faculty of Health and Social Development
University of British Columbia – Okanagan Campus

[PREVIOUS EMAIL Thread]

Appendix C

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Consent Form

Study Team

Principal Investigator: Dr. John Graham, Director and Professor, School of Social Work, University of British Columbia Okanagan, 250-864-7118, john.graham@ubc.ca

Co-Investigator/Graduate Student Researcher: Savanna Belitski, Masters Student, School of Social Work, University of British Columbia Okanagan, 306-550-9708, belitsks@ubc.ca

Purpose of the Study

This study is being conducted to learn more about the current practices of community-based organizations in providing services to women-identified survivors of domestic violence experiencing co-occurring substance use challenges. As a professional working in an organization that provides combined services for this population, we hope to learn from your professional insight into how combined services are being provided.

Study Procedures

- If you agree to participate in the study, a 1-hour phone, video, or in-person interview will be scheduled;

- The interview will be audio recorded with your permission and conducted using a UBC licensed Zoom account;
- During the interview you will be asked questions about your agency's mandate, practices, and successes and challenges in offering combined services;
- The questions will be open-ended, so you will be able to elaborate on your responses as much as you'd like and always have the option to decline questions;
- After the interview you will be emailed the transcript of your responses and will have two weeks to provide feedback to ensure the information accurately reflects your perspectives. In absence of a response, it will be assumed you have received the email. If no feedback is provided after two weeks, it will be assumed that the transcript is acceptable;

Your response to the following **does not** impact eligibility to participate in the study.

☐ Please check here if you give permission to the interview being audio recorded.

Study Results

The results of this study will be reported in a graduate thesis and made publicly available on the internet. It is possible, though not anticipated, that the data may be utilized in future research, at which point you would be contacted with details for consent to utilize the data you contributed at that point in time. At any point prior to the submission of the thesis you are welcome to withdraw your contributed data from the study and it will be destroyed. Upon thesis submission it becomes impractical, though not impossible, to delete the data.

☐ Please check here and provide your email address if you would like to be emailed with the results of the study: _____

Potential Risks and Benefits of the Study

Risks: Conversations about domestic violence and substance use have the potential to be difficult or upsetting. Although interview questions are limited to service delivery and not experiences of violence or substance use themselves, the options to take breaks, skip questions, and end the interview will be present at all times.

It is respected that, as a professional in a community-based organization, the majority of your capacity must be devoted to your work directly with individuals and families impacted by domestic violence and substance use. A risk in participating in the interview is that it may have an impact on your availability to your clients, both emotionally and logistically, by requiring 1 hour of your time. The interviewer will do their best to be respectful of your time and accommodate your schedule to limit impact on clients and financial impacts to your practice.

Benefits: The outcomes of this research are intended to serve as a means of strengthening the programming and services available for women experiencing both domestic violence and substance use challenges in hopes of improving healing outcomes for individuals. By identifying common themes in the successes and challenges among agencies, this research hopes to provide useable information on best practices and pitfalls to guide agencies in program development for this population.

Confidentiality

Your confidentiality will be prioritized. Information that discloses your identity will not be released without your consent unless required by law.

All audio recorded materials will be stored on a UBC secured server. Once recordings are verified, recordings will be deleted.

All data will be stored and backed up in Canada. All paper materials will be stored in a locked filing cabinet. Materials containing identifying information will be stored separately from the data. Electronic files will be encrypted and password protected. The data will be accessible only to the Primary Investigator, the Co-Investigator and the two additional Supervisory Committee Members. Data will be kept by the Primary Investigator at the institution indefinitely, as per UBC Policy SC6.

Contacts for Information about the Study:

If you have any questions or desire further information with respect to this study, you may contact the researchers carrying out this study. Contact information is provided above.

Contacts for Complaints:

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Services toll free at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. It is also possible to contact the Research Complaint Line by email (*RSIL@ors.ubc.ca)*. Please reference the study ID H23-00741 to facilitate the handling of your concern.

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from this study at any time.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Participant signature:_____ Date: _____

Printed name of the participant signing above: _____

Appendix D

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Interview Guide

Locating the Researcher

Interest in the Topic: Separate from this research, I have worked in the field of domestic violence for the last 5 years. These roles have included direct frontline support in emergency domestic violence shelters in Saskatchewan and British Columbia as well as roles as a Program Coordinator and Program Manager at a second stage domestic violence housing program. This research topic arose out of my professional experiences serving women survivors of domestic violence with co-occurring substance use concerns and recognizing the challenges that many community-based organizations face in adequately meeting the complex needs of these clients.

Philosophical Approach to Research: My approach to this qualitative research is rooted in Feminist Theory which originated from social movements. Whenever possible I would like my research to be accessible, in terms of writing style and availability, inclusive, in terms of who is represented, and actionable. There are limits to my perspective as a settler-colonial, white, cis, bisexual, able-bodied, neurotypical woman operating within a colonial institution. I acknowledge the impacts my positionality has on representation within my research and am receptive to critique and criticism in all forms.

1. Can you tell me about your agency generally, including the populations you serve and the services you offer?
2. How does your agency currently support women-identified clients experiencing co-occurring DV and problematic SU?
    a. What policies or formal procedures does your agency have in place to support the provision of these services?
    b. Has addressing the unique needs of women experiencing both DV and SU required any recent or historical changes or adaptations to your service delivery? Can you provide details of these changes and motivation for changes?
3. What successes has your agency seen in providing combined programming for DV and SU?
    a. What aspects of your agency's service design or delivery do you believe has influenced these successes?
4. What challenges, limitations or barriers has your agency experienced in offering combined services for DV and SU?
    a. What solutions do you think would be helpful in addressing these specific limitations/barriers?
    b. How could current service designs be improved to better support women-identified survivors experiencing problematic SU?
5. What would an ideal service model for this population look like?

6. At what level do you think existing program barriers can be most effectively addressed/at what level does the most change need to occur? (ex. government, agency, individual staff attitudes, etc.)
7. What do you believe are the unique or pressing needs among women experiencing co-occurring domestic violence and substance use challenges?
    a. How are these needs different from women experiencing only domestic violence or only substance use challenges?
8. What is your knowledge of the extent to which other agencies/communities are implementing similar combined services?
    a. Do you know of any other agencies that you believe could offer valuable knowledge and insight to this study?
9. Lastly, is there anything that we haven't discussed that you feel is important for me to know about your services?