

A Narrative Exploration of Service Providers' Understanding of the Relationship
Between Co-Occurring Mental Health and Substance Use Issues Among Women in Nova
Scotia.

by

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TABLE OF CONTENTS

| | |
|--|------|
| LIST OF TABLES | v |
| ABSTRACT | vi |
| LIST OF ABBREVIATIONS USED | vii |
| ACKNOWLEDGEMENTS | viii |
| CHAPTER ONE: INTRODUCTION | 1 |
| Relationship Between Mental Health and Substance Use..... | 1 |
| Mental Health and Substance Use in Nova Scotia | 2 |
| Purpose of Thesis | 5 |
| Rational for Study | 6 |
| Use of Theory | 8 |
| CHAPTER TWO: LITERATURE REVIEW..... | 12 |
| Conceptual Approaches to Language | 12 |
| Relationship Between Mental Health and Substance Use | 14 |
| Integrated Treatment Approaches | 16 |
| Women-Centered Treatment for Co-Occurring Issues | 19 |
| Service Provider Narratives | 24 |
| Barriers to Treatment | 27 |
| CHAPTER THREE: METHODOLOGY..... | 30 |
| Research Question and Objectives | 30 |
| Research Design | 31 |
| Participants and Sampling | 33 |
| Data Collection | 34 |
| Data Analysis | 36 |
| Confidentiality and Anonymity | 38 |

| | |
|--|------------|
| Ethical Issues | 40 |
| CHAPTER FOUR: FINDINGS..... | 42 |
| Descriptive Overview of Participants | 42 |
| Narrative Interviews: Experiences of Service Provision | 44 |
| Service Provider Understanding of the Relationship | 45 |
| Connections Between Theory and Practice | 54 |
| Development and Description of Ideology | 69 |
| Barriers to Service Provision | 73 |
| Recommendations For Change | 94 |
| CHAPTER FIVE: DATA ANALYSIS..... | 99 |
| Unpacking the Relationship Between Co-Occurring Issues | 99 |
| Making Connections Between Theory and Practice | 105 |
| Barriers To Practice and Institutional Ideology | 108 |
| Service Provider Recommendations | 115 |
| Implications for Social Work Practice | 118 |
| CHAPTER SIX: CONCLUSION..... | 120 |
| Summary | 121 |
| Strengths and Limitations | 122 |
| Areas of Further Exploration | 125 |
| Final Reflections | 126 |
| REFERENCES..... | 127 |
| APPENDIX A: Informed Consent Form | 138 |
| APPENDIX B: Recruitment Script | 144 |
| APPENDIX C: Demographic Questionnaire | 145 |
| APPENDIX D: Interview Guide | 147 |

| | |
|-----------------------------------|-----|
| APPENDIX E: Approval Letter | 150 |
|-----------------------------------|-----|

LIST OF TABLES

| | |
|--|----|
| Table 1: Demographic Information | 43 |
| Table 2: Overview of Models, Perspectives, and Theories Associated With Practice ... | 55 |

ABSTRACT

This qualitative study explored narrative accounts of how service providers in Nova Scotia understand and work with the relationship between co-occurring mental health and substance use issues. More specifically this research focused on understanding and working with this relationship among women. This concept was explored through in-depth narrative accounts of service provider experiences who work in the field of mental health and/or substance use and who have experienced working with women that identify as experiencing both co-occurring issues. In-depth one-on-one interviews were conducted with master's level social workers (MSW). Data was analyzed using methods consistent with a narrative inquiry approach (i.e., thematic analysis and discourse analysis).

The findings of this study were consistent with current literature suggesting that the relationship between mental health and substance use, especially among women, is complex and still not entirely understood. Service provider narratives contain contradictory stories about etiology and interaction. Participant narratives spoke to their understanding of a strong relationship existing between co-occurring issues as well as using substance use as a secondary coping response to mental health and trauma. Service providers identified a number of treatment barriers affecting their practice in working with women (i.e., institutional ideology, organizational, and women's socioeconomic, political, cultural and historical experiences). Service providers also identified primarily eclectic approaches to intervention and treatment in working with women who experience co-occurring issues. This research contributes to the growing discussion on how front-line mental health and addiction service providers are working with and implementing the new Mental Health and Addiction Strategy in Nova Scotia.

LIST OF ABBREVIATIONS USED

| | |
|-------|----------------------------------|
| BDP | Borderline Personality Disorder |
| BSW | Bachelor of Social Work |
| CBT | Cognitive Behavioural Therapy |
| CP | Child Protection |
| IA | Income Assistance |
| LGBTQ | Lesbian Gay Bisexual Trans Queer |
| MSW | Master of Social Work |
| NS | Nova Scotia |
| PTSD | Post Traumatic Stress Disorder |

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CHAPTER ONE: INTRODUCTION

Co-occurring mental health and substance use issues are continually becoming a prominent topic in research, health care, and treatment services. This introductory chapter will outline the framework of this study and provide a context for the research topic. It will include a an overview of information pertaining to co-occurring mental health and substance use in Nova Scotia as well as an introduction into the Mental Health and Addictions Strategy currently being followed. This chapter will also provide the purpose of this study and an overview of the theoretical framework. The following chapter will be a review of relevant literature pertaining to the research topic and the third chapter will outline the design and methodology used to carry out this study. Chapter four will discuss the findings of the research in a results section, and chapter five will provide an analysis of those findings. Chapter six will offer a final conclusion and summary.

Relationship Between Mental Health and Substance Use

The relationship between mental health and substance use is both complicated and intersecting. Many individuals experiencing substance use issues also experiencing mental health concerns and vice versa. This population can represent some of the most difficult cases to treat. In the literature, this relationship is often referred to as co-occurring, coexisting or concurrent disorders and is defined as, “any combination of mental health and substance use disorders, as defined for example on either Axis I or Axis II of DSM-IV” (Health Canada, 2002, p. v). Other terms used to refer to this relationship consist of dual diagnosis or comorbid disorder (Drake et al., 2001). In this study, co-occurring mental health and substance use issues exist when at least one of each issue are present concurrently in an individual (Villena, 2008). Due to the large number

of variations present within this population and recognizing the implicit use of psychiatric discourse, Health Canada (2002) identifies five subgroups within the broader definition of co-occurring mental health and substance use issues (i.e., co-occurring substance use and mood and anxiety disorders; co-occurring substance use and severe and persistent mental illness; co-occurring substance use and personality disorders; co-occurring substance use and eating disorders; and other co-occurring substance use and mental health disorders) (p. vii). The use of language in this study is intentional however use of psychiatric discourse is necessary when discussing relevant literature. This will be further explored both in the study's literature review as well as the analysis.

Mental Health and Substance Use in Nova Scotia

Nova Scotia's Department of Health and Wellness (2012) developed a Mental Health and Addictions Strategy Advisory Committee that produced a report stating by 2030, issues regarding mental health and substance use will be the leading cause of (dis)Ability in Canada. This report also suggests that one in five Canadians experience a diagnosable mental health issue and one in seven struggle with alcohol and/or drug related issues (Government of Nova Scotia, 2012). Of these individuals seeking support for mental health issues, 15 to 20% of them are also experiencing substance use issues (Nova Scotia's Department of Health and Wellness, 2012). Other research asserts this number is much higher, ranging between 30 and 50% in mental health treatment settings (Todd, Sellman, & Robertson, 2002). Likewise, it has been estimated that more than half of people seeking support for substance use issues are also living with mental health issues (Krausz, 2009; Nova Scotia's Department of Health and Wellness, 2012).

Additionally, Nova Scotia's Department of Health and Wellness (2012) acknowledge that

women experience distinct challenges and barriers when dealing with these issues compared to men. These need to be taken into consideration with the development of service provision in order to reduce barriers and marginalization.

Despite this, services for mental health and substance use have historically been fragmented, divided and underfunded (Drake et al., 2001; Krausz, 2009; Nova Scotia's Department of Health and Wellness, 2012). Drake and colleagues (2001) have suggested that many clients are, “unable to navigate the separate systems or make sense of disparate messages about treatment and recovery. Often they are excluded or extruded from services in one system because of the comorbid disorder and told to return when the other problem is under control” (p. 470). These individuals tend to have more difficulty engaging in the health care system and frequently utilize 24-hour emergency services when in crisis (Schütz et al., 2013).

In order to attempt to address these concerns, the government of Nova Scotia has constructed a strategy in order to provide better service provision in the field of mental health and addictions. This strategy suggests a five-year plan that aims to achieve several outcomes that include: targeting youth and promoting prevention; collaboration and integration of mental health and addiction care systems; inclusion and diversity; closing the gaps between program transitions; and addressing stigma and discrimination (Department of Health and Wellness, 2012). One of the most significant components in addressing service provision for co-occurring mental health and substance use issues, is the amalgamation, collaboration, and integration of mental health and addiction services. Though it speaks very little to the issues of women accessing these services.

The Department of Health and Wellness has released progress updates in 2013, 2015, and January 2016 outlining steps they have taken to implement the plan since 2012. It appears that there has been significant progress across all five key priority areas with 28 of 33 actions being worked on or completed as of January 2016. A few of the highlights from the latest report involve the Nova Scotia government taking steps to: provide early intervention through several different programs (e.g., The Strongest Families Program, placing mental health clinicians in schools, and ensuring 18 month screenings for physical and cognitive health issues); reduce stigma by training family doctors and increasing awareness and programming in the workplace; increase services in Aboriginal communities as well as offering diversity training to clinicians; expand housing options through the hiring of housing workers throughout the province; decrease wait times, expand opioid replacement treatment programs, expand peer support programs, expand the Mental Health Crisis Line and provide ‘concurrent disorder’ training for care providers. The 2015 report highlights their progress in providing collaborative care among primary, mental health and addictions service providers through the implementation of the Bloom Program which allows pharmacists to support mental health service users through medication therapy and system navigation. The 2016 report also states that they have provided \$2.6 million to 37 community-based organizations.

Although these are all important and necessary steps to provide better services to individuals and families experiencing co-occurring mental health and substance use issues, the progress reports do not demonstrate how Nova Scotia’s Mental Health and Addictions Program have amalgamated and integrated their programs to provide holistic and comprehensive care to individuals experiencing these issues concurrently. There is

also no mention of gender specific programming or the inclusion of trauma in the treatment of mental health and substance use.

Purpose of Thesis

Research areas around mental health and substance use have always been of particular interest to me. Completing an undergraduate degree in psychology and finding feminist discourse, my research interests have developed to become particularly focused on women-centered treatment and care. My attention to these issues has only focused and intensified after years of working in the community and learning from an academic and professional standpoint. I have witnessed first hand some of the issues clients experience in our formal healthcare systems in attempting to gain access to treatment for co-occurring mental health and substance use. Many clients I have worked with have struggled to find the ‘right fit’ in treatment and have been pathologized as “non-compliant” in institutionalized treatment settings, which has resulted in lack of other options. I have worked with clients who have felt powerless and experienced a loss of hope. I have also shared these feelings of powerlessness with those I have been unable to support and advocate for with our formal systems. Often these experiences have been working with marginalized women with who experienced trauma, mental health, and/or substance use issues. These feelings of powerlessness have encouraged me to continue to explore how our systems operationalize and how our clinical practitioners work with these issues.

As a feminist based practitioner, my practice continues to lean towards working with the relationship of mental health, substance use, and trauma among women. My theoretical framework has been integral to my developing practice approaches, which has

led and directed my interest in exploring the integration of theory and practice in my research and the research of others. Exploring how service providers work with and understand co-occurring mental health and substance use seemed like a natural fit for me to further explore the relationship between theory and practice.

This study is occurring at an integral time in Nova Scotia's history of service provision targeted at mental health and substance use due to the recent amalgamation of services in this area. This is a qualitative study exploring narratives of how service providers in Nova Scotia understand and work with the relationship between co-occurring mental health and substance use issues. More specifically this research focuses on understanding and working with this relationship among women. This concept is explored through in-depth narrative accounts of master's level social workers (MSW) who work in the field of mental health and/or substance use and who have experienced working with women that present with both co-occurring issues. Through the exploration of service provider narratives, this study sought to explore stories and experiences related to their theoretical frameworks and intervention approaches. The purpose of this study is to contribute to the growing discussion on service provider understanding of co-occurring mental health and substance use as well as provide insight into how individuals in the field are working with this population.

Rational for Study

Given that the purpose of this study is to gain an in-depth understanding of the experiences of service providers in Nova Scotia who are working with co-occurring mental health and substance use issues, this research hopes to contribute to the discussion of empirical knowledge and practice-related theory associated with understanding how

those who work in this field understand the relationship between concurrent issues as well as how they work with implementing intervention approaches. Exploring this topic is important to the growing body of knowledge and research in Nova Scotia because:

1. Individuals with co-occurring mental health and substance use issues have continuously come into contact with a mental health system that embodies policies, programs, and practices that have historically been developed separately from those that address substance use issues. These systems in Nova Scotia have suffered from poor organization and a lack of integration (Blakely & Dziadosz, 2007; Government of Nova Scotia, 2012; Health Canada, 2001; Ostrander, 2009; Nova Scotia Department of Health and Wellness, 2012).
2. In recent years the provincial government of Nova Scotia has introduced a strategy to amalgamate mental health and addictions services in order to improve province wide service provision. One of the primary reasons for the amalgamation of these services was due to systemic issues of lack of collaboration between mental health and substance use care systems as well as gaps in service provision addressing both issues. Historically clients have been shifted back and forth between mental health and addiction programs (Drake et al., 2001; Government of Nova Scotia, 2012; Nova Scotia Department of Health and Wellness, 2012).
3. Research has shown clients with co-occurring mental health and substance use (and trauma) issues are more successful in treatment when they are addressed simultaneously (Blakely & Dziadosz, 2007; Drake et al., 2001; Drake, Mueser, & Brunette, 2007; Ford-Gainer, 2009; Jaynes, 2008; Krausz, 2009; Schütz et al., 2013; Skinner, 2005; Halfpenny-Weir, 2009).

4. This research aims to contribute to the discussion on how front-line mental health and addiction service providers are working with and implementing this new strategy in Nova Scotia.

Use of Theory

Service provider experiences are intentionally examined through postmodern and poststructural feminist and narrative theoretical lenses that include concepts of positionality and both/and reflexive approaches to critical thought (Brown, 1994; 2007; 2012; Brown & Augusta-Scott, 2007; Fook, 2002; Fook, 2012; White, 2007). Beardsley and Miller (2002) state that, “feminist research attends to the political realities of participants’ lives, the research context, and the research itself and centralizes gender and power dynamics as a lens for understanding oppressed groups” (p. 59). Feminist thinking is derived out of a wide range of differing perspectives that are concerned with the domination of women through patriarchy and sexism. Feminist theory is rooted in a belief system that asserts there are dominant social structures that work to privilege and empower men while simultaneously oppressing women (Dominelli, 2002a). bell hooks offers a simple and eloquent definition of feminism as, “a movement to end sexism, sexist exploitation, and oppression” (2000, p. 1).

Van Den Bergh & Cooper (1986) suggest that there are five principles central to holding a practical feminist framework: eliminating false dichotomies; valuing process equally to valuing product; renaming one’s reality; the reconceptualization of power; and acknowledging the personal is political (p. 4). Dominelli (2002a) outlines feminist social work practice as a form of practice:

...that takes women's experience of the world as the starting point of its analysis and by focusing on the links between a woman's position in society and her individual predicament, responds to her specific needs, creates egalitarian relations in 'client'-worker interactions and addresses structural inequalities.

Meeting women's particular needs in a holistic manner and dealing with the complexities of their lives – including the numerous tensions and diverse forms of oppression impacting upon them, is an integral part... (p. 7)

Remaining grounded in a feminist framework will allow for a specific socio-political analysis and continually guide the study in a women-focused direction. Feminist approaches will provide an analytic tool to view issues of mental health and substance use through the socio-political structures that disempower and disenfranchise women through the perpetuation of patriarchy.

Narrative theory is rooted in social constructionism and based on the assumption that we are continuously forming ideas about ourselves and others and these ideas contribute to our notions of reality. This kind of knowledge construction is derived from the use of language or discourse with particular cultural and historical contexts (Foucault, 1980). Dominant discourses shape our lived experiences, ideas about the world, relationships with others, and expressions of life (Brown & Augusta-Scott, 2007; Foucault, 1980; Healy, 2005; White, 2001). Fook (2002) argues that language, discourse and power are inextricably linked. This relationship provides a means for power to operate through the, "control of discourses" (p. 66). The pervasive acceptance of certain normative "truths" or taken-for granted understandings of the world operates as a

function of power (Fook, 2002; Foucault, 1978; White, 2001). As a precursor to these thoughts, Foucault (1980) states:

...in any society, there are manifold relations of power which permeate, characterise and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse. There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association. (p. 93)

Brown and Augusta-Scott (2007) state that, “the narrative metaphor conveys the idea that stories organize, structure, and give meaning to events in our lives and help us make sense of experiences” (p. ix). Narratives are grounded in the idea that, “we do not have direct knowledge of the world. We cannot have an objective description of reality. Instead, what we know of the world we know through our experience of it” (White, 1989, p. 1). White (1994) further contends there are no neutral telling or hearing of stories. In narrative research, the researcher is also a participant in the conversation, with her own contextual histories and belief systems. Stories must be told, retold, deconstructed and reconstructed (Brown & Augusta-Scott, 2007; White, 1991). There is no single telling of a story nor can they be interpreted in a vacuum (Brown & Augusta-Scott, 2007; White, 1989; 1994). White (1989) states that:

Our lives are multi-storied. No single story of life can be free of ambiguity and contradiction. No sole personal story or narrative can handle all of the contingencies of life... The personal story or self-narrative is not neutral in its effects... (p. 4)

Therefore we live multi-storied lives that are co-constructed with multiple authors.

The concept of positionality, described by Brown (2007; 2012), contends that everyone is positioned in one-way or another and not all positions are viewed as equal (i.e., the idea that everyone has their own set of values, beliefs, assumptions, and biases about how the world is socially constructed). Adopting a both/and approach to modernist and postmodernist thought allows for incorporation and application of both perspectives into the chosen theoretical frameworks. Modernism provides a means for remaining positioned in social justice and implementing a socio-political analysis. Postmodernism allows for the rejection of essentialism and objectivity while using concepts such as deconstruction, reflexivity and intersectionality to explore and analyze ideas. Brown (2007) asserts that, “by blending modernist and postmodernist approaches, one can adopt a position and have a vision for social change without claiming to hold on to an absolute truth... This “both/and” position allows one to make truth claims, while acknowledging they are always socially constructed, located, and incomplete” (p. 11). Adopting a both/and approach to the feminist and critical frameworks that influence this study is essential because it not only guides the interview questions but also aids in data analysis. This perspective is especially influential in exploring participant beliefs and values around practice (e.g., are service providers positioned in a particular viewpoint, do they aim for political neutrality, etc.).

CHAPTER TWO: LITERATURE REVIEW

Conceptual Approaches to Language

In keeping with a postmodern/poststructural feminist and narrative approaches to research, this study makes intentional uses of language when discussing concepts such as mental health and substance use. Given that we derive meaning and make sense of the world around us through the use of language and discourse, this study intends to use language in a manner that promotes a non-essentialist worldview while allowing space for complex narratives of individuals and groups experiencing co-occurring mental health and substance use issues (Brown, 2007b; Brown, 2012). Concepts such as mental health and substance use are socio-political issues that can perpetuate the oppression women face.

Coates and Wade (2007) state that the, “strategic use of language is indispensable to the acquisition and exercise of power” (p. 511). They go on to state that, “key institutions (e.g., education, medicine, law enforcement, criminal justice, military, corporate, electoral) publicize their ideologies, policies, and objectives as guidelines for social practice” (p. 511). Psychiatric discourse has been largely accepted as the dominant norm if not as fact (Strong, 2012; Strong, Gaete, Sametband, French, & Eeson, 2012). Although this terminology is commonly used and can be useful for both assessment and evaluation, this study will strive as much as possible to be conscious of the language used and its contextual place in a medicalized society. This is not to dismiss psychiatric discourse, as its place in the literature requires its use in this study. Rather it involves recognizing and understanding its foundation in dominant social constructs.

Issues with mental health, often termed as mental illness or mental disorder, are defined and evaluated in several different ways. Pollet (2007) defines mental health as something that is, “created in our interactions with the world around us, and is determined by our sense of control in dealing with our circumstances and by the support we have to help us cope” (p. 1). The World Health Organization (2005) defines mental health as, “a state of well-being in which the individual realizes [their] own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community” (XVIII). For the purposes of this study, mental health issues will be viewed in terms of a concept described by Gehart (2012) that asserts, “a person’s experience of “mental illness,” including his or her sense of autonomy and personal identity, is informed by broader societal discourses, which must be questioned and reexamined in the process of recovery” (p. 436). These definitions allow space for individuals to have their own subjective narratives of mental health and mental illness, rather than the automatic application of a label through psychiatric discourse.

This study views substance use on a continuum where it is defined as the use of alcohol and/or other drugs, other than prescribed medications being used safely and as prescribed, which includes a spectrum of use from occasional to frequent to dependent (Fisher & Harrison, 2009). Substance use issues, substance abuse/misuse and addiction, are generally characterized by the level of disruption it causes in the person’s life. It can involve levels of problematic use or dependence where use is both predictable and recurrent. The individual is often incapable of abstaining due to psychological or physiological need and will continue to use despite negative consequences. Often substance use issues lead to and/or result from problems with: behavioural control,

interpersonal relationships, and emotional regulation (Department of Health and Wellness, 2012).

Relationship Between Mental Health and Substance Use

Mental health and substance use have a complicated relationship where having one issue increases the risk of developing the other. How these issues actually interact is continuously being called into question (i.e., does substance use cause mental health issues to arise or are individuals using substances to cope with mental health issues). These factors need to be taken into consideration with historical context and environmental experiences and how they impact mental health and substance use. Further, some of the behaviours that arise out of substance use issues can present as mental health related (e.g., drug-induced psychosis). When this is the case, these behaviours tend to improve with a reduction in substance use (Skinner, 2005).

Individuals who experience co-occurring mental health and substance use belong to some of the most marginalized and vulnerable groups in society. They experience high rates of negative outcomes such as: high rates of relapse, medication noncompliance, violence, poverty, homelessness or unstable housing, hospitalization, HIV and hepatitis, participation in the sex trade, incarceration, suicide and lowered life expectancy (Krausz, 2009; Drake et al., 2001; Drake & Mueser, 2000). Women experience these issues at increasingly high rates, which are often coupled with experiences of family, intimate partner and sexualized violence. The British Columbia Centre of Excellence for Women's Health (2009) refers to the relationship between trauma/violence, mental health, and substance use as, "profound and staggering." They go on to state that, "as many as 2/3 of women with substance use problems report a

concurrent mental health problem (e.g. PTSD, anxiety, depression) and they also commonly report surviving physical and sexual abuse either as children or adults” (p. 2).

Degenhardt, Hall, & Lynskey (2003 as cited in Skinner, 2005) suggest that there are four potential models that can provide some insight into explaining co-occurring issues. The first is the common factor model, which posits that it is the same set of biopsychosocial factors that contribute to both mental health and substance use issues. The second model, referred to as the secondary substance use model, asserts that it is the presence of mental health issues that increase ones chances in developing a substance use issue (i.e., individuals use substances as a means to cope with anxiety, emotional dysregulation, mood related issues, and post traumatic stress). The third model is known as the secondary mental health model, which contends that individuals develop mental health issues who would not have otherwise developed them due to substance use. Both the second and third models suggest there is a temporal relationship between mental health and substance use. The final model that Degenhardt et al. (2003) suggests is the bidirectional model. This model contends that the presence of one issue (e.g., substance use) can increase susceptibility to problems in the other area (e.g., mental health). The development of the second issue can be exacerbated by the negative outcomes experienced by the first issue (e.g., difficult interpersonal relationships, job loss, unstable housing, poverty, etc.). The model one chooses to use in practice may be dependent on client narratives and histories. Despite the chosen model, individuals who concurrently experience these two issues are far from a homogeneous group. Several different combinations of substance use and mental health issues can exist and therefore can lead to different outcomes (Todd, Sellman, & Robertson, 2002). Research has also shown that

gender differences may exist in the relationship between mental health and substance use and therefore standardized models may or may not apply to work with women (Brown & Stewart, 2008; Kessler et al., 1997). For example, research has shown that depression most often occurs first in women and is followed by alcohol misuse as a method of self-medication. This is in comparison to men, who most often experience depression after the onset of alcohol misuse (Brown & Stewart, 2008; Kessler et al., 1997).

Integrated Treatment Approaches

Mental health and substance abuse services have typically been separate from one another and have often operated from opposing standpoints (Drake et al., 2001; Health Canada, 2002). There is mounting evidence to suggest that for individuals with co-occurring mental health and substance use issues, providing parallel treatment or having programs that do not treat both issues concurrently is relatively ineffective and produces poor client outcomes (e.g., relapse, re-hospitalization, noncompliance, and higher drop-out rates) (Drake, 2001; Drake, Mueser, Brunette, & McHugo, 2004; Krausz, 2009). Conversely, it has become widely accepted that improved service provision and positive client outcomes in this population is associated with an integrated treatment approach (Drake et al. 2001; Drake et al., 2004; Health Canada, 2002; Skinner, 2005; Stewart & Brown, 2007a). Often times integrating treatment can provide an uneasy fit for both systems due to historical philosophical and cultural differences existing between both systems. Mental health has been critiqued for it's tendency to operate from medicalized, pathologized, and hierachal model (Morley, 2003), while addiction services have been critiqued for both subscribing to a 'self help' disease model of practice as well viewing substance use as entirely behavioural in nature (Barnett & Fry, 2015; Capital Health, 2011; Hammer et al., 2013; Brown, Stewart, & Larsen, 2009). The Health Canada (2002)

report on Concurrent Disorders goes as far to state that, “Acceptance of the medical/psychiatric framework underlying the DSM, or other mental health classification systems, may be one of the challenges that key stakeholders and planners need to overcome in bridging the worlds of mental health and substance abuse” (p. 8).

Skinner (2005) suggests that integrated treatment is based on the assumption that there is a relationship between mental health and substance use issues and that the two should be treated concurrently. Integrated treatment arose out of the issues clients experience in navigating complex separate systems that often exclude clients with co-occurring issues (Drake et al., 2001; Drake & Mueser, 2000; Drake et al., 2004). Integrated treatment exists when the intervention approaches for co-occurring mental health and substance use are combined into one treatment setting (i.e., one clinician or team of clinicians are responsible for organization and facilitation of a blended treatment approach that targets both mental health and substance use (Drake et al., 2004; Skinner, 2005). This removes the responsibility of navigating complex treatment systems away from clients and places it onto policy makers, organizations, and service providers (Drake et al., 2004).

Health Canada (2002) suggests there are two levels of integrated treatment: program integration and system integration. Program integration involves the concept that one clinician or team of clinicians provides both mental health and substance use treatment within the same program or treatment setting. This ensures the individual is receiving harmonious explanations and services that do not exist in contradiction to one another (as in parallel treatment approaches). System integration offers a means for existing systems to improve without the cost of having to completely rebuild the

programs. Health Canada (2002) defines this as:

The development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan. (vii)

Drake et al. (2001) conducted a review of eight studies on integrated treatment approaches with experimental or quasi-experimental designs. All of these studies found positive client outcomes in several different areas (e.g., substance use, mental health symptoms, housing, hospitalization, legal issues, quality of life, etc.). Based on this review, they compiled a list of critical components present in all of these studies that contributed to positive outcomes: staged interventions (i.e., stages of treatment); assertive outreach (i.e., engaging clients in their support system through intensive case management strategies); motivational interventions (i.e., harm reduction, goal construction, and motivational interviewing approaches); counseling; social support interventions; long-term perspectives and treatment plans; comprehensiveness (i.e., all aspects of program are tailored to individual); and cultural sensitivity and competence.

Due to the heterogeneous nature of this population, there is no prescribed set of interventions that will be effective for all clients experiencing concurrent issues (Skinner, 2005). Though Health Canada (2002) does suggest a set of ‘best practice’ evidence-based interventions for each of the five subgroups. For example, in a situation where an

individual is experiencing substance use and co-occurring anxiety and/or mood disorders, they recommend treatment involves continuous assessment, sequencing specific intervention strategies beginning with substance use, and adjusting the treatment plan if the anxiety or mood related issue(s) does not improve once the substance use issue improves. This strategy is coupled with cognitive-behavioural therapy (CBT). Although this may be the recommendation of Health Canada, the ‘best practices’ combining mental health and substance use treatment have not been widely adopted across the provinces as mental health and addiction services have not completely amalgamated in practice (Drake et al., 2001; Krausz, 2009; Nova Scotia’s Department of Health and Wellness, 2012). It could be further argued that the ‘best practices’ cited by Health Canada are rooted in dominant discourse and medicalized treatment models which may actually be more harmful than helpful to women seeking treatment for substance use and mental health (Brown & Stewart, 2008). The neoliberal promotion of fast, efficient, and cost-effective treatment options are often legitimized through evidenced based ‘best practices.’ Neoliberal ideology towards treatment promotes the individual ‘responsibleisation’ and removes societal, institutional, and political accountability (Esposito & Perez, 2014; Teghtsoonian, 2009).

Women-Centered Treatment for Co-Occurring Issues

It is apparent that more attention needs to be paid to women who experience co-occurring mental health and substance use issues given that research shows gender-based and trauma-specific treatment approaches provide more appropriate treatment lenses and lead to better outcomes in women (British Columbia Centre of Excellence for Women's Health, 2009; Brown & Stewart, 2007; Brown & Stewart, 2008; Covington, Burke, Keaton & Norcott, 2008; Gatz et al., 2007). Trauma must be considered when creating

integrated treatment approaches targeted specifically at the complex needs of women (Brown & Stewart, 2008; Covington et al., 2008; Koehn & Hardy, 2007; Krausz, 2009; Najavits, 2007). Current research suggests that 55% to 99% of women experiencing co-occurring issues have also experienced some form of trauma (Covington et al., 2008). Although both men and women report using substances to cope with trauma, there is the strong relationship that exists between violence against women and substance use (Covington et al., 2008). In a review of epidemiological evidence looking at gender differences in post traumatic stress disorder (PTSD), Norris, Foster, and Weisshaar (2002) noted that women are twice as likely to develop PTSD after a traumatic event and the symptoms tend to persist up to four times longer in women compared to men. In women who experience co-occurring issues, it has been demonstrated that they also experience higher rates of burden in other aspects of their lives (e.g., homelessness or unstable housing, HIV, other health related issues, sexual assault, intimate partner violence, unemployment, and lone parenting) (Brown, Huba, & Melchior, 1995; Kang, 2007). Women with co-occurring issues historically have not been offered adequate services responsive to their complex needs. High levels of treatment drop out are a continuous problem with women belonging to this group, especially with those who have children (Brown et al., 1995; Gatz et al., 2007). Barriers to women seeking treatment who have children are complex, however often there is a concern related to child protection and fear of removal. Understanding and treatment of mental health, substance use, and trauma often ignore context and therefore deny, “the social, political, and economic realities of women’s lives” (Lafrance & McKenzie-Mohr, 2014, p. 17).

Additionally, research has found differences in occurrence, prevalence and

presentation of co-occurring mental health and substance among men and women (Brown & Stewart, 2008; Kang, 2007; Kessler et al., 1997; Koehn & Hardy, 2007; Stewart, Karp, Pihl, & Peterson, 1997; Merikangas et al., 1998; Tjepkema, 2004). As an example, Koehn & Hardy (2007) observe that women who experience substance use issues are significantly more likely than their male counterparts to also experience depression. Kang (2007) reports that in comparison to men, women who are dependent on alcohol are more likely to experience higher rates of social phobia, simple phobia, and PTSD. Kessler and colleagues (1997) found that women are more likely than men to develop anxiety or mood related issues before alcohol issues. It is noted in Brown and Stewart (2008) that women are more likely than men to drink in response to depression.

Moreover, it has been found that women who experience substance use issues are more likely to develop mental health issues, such as depression and anxiety, than women in the general population (Kang, 2007; Koehn & Hardy, 2007). Women who experience major depression or mixed depression and anxiety tend to have higher rates of alcoholism in comparison to women who do not experience mental health issues (Koehn & Hardy, 2007). Likewise, when compared to the general population, women with substance use issues are more likely to experience co-occurring eating issues (Stewart & Brown, 2007b). In a study done by Stewart, Brown, and colleagues (2006) exploring binge eating behaviours in a sample of women being treated for alcohol through Nova Scotia's Addictions Prevention and Treatment Services, it was found that 71% of women self-reported binge eating patterns, with a significant amount reporting severe patterns. Awareness of these factors is integral in developing policies and programs that incorporate women centered treatment for co-occurring mental health and substance use.

There are several different ideas regarding best practice approaches for treating women with mental health and substance use issues. Differing approaches for women could be dependent on the mental health issues present and substances being used. Koehn & Hardy (2007) suggest that taking a women-centered biopsychosocial approach is helpful in assessment and treatment contexts of depression and substance use. They state that women who experience both of these issues benefit from counseling, which focuses on empowerment and self-efficacy. Kang (2007) asserts that as symptoms of anxiety are related to relapse in individuals with co-occurring issues, therefore, it is important in treatment contexts to decrease anxiety levels in order to continue with substance use treatment. She also promotes the use of medication and psychosocial therapies (e.g., CBT) in order to treat co-occurring anxiety and substance use issues. Within the context of co-occurring eating issues and substance use, Stewart and Brown (2007a) contend that the relationship between binge eating and substance use problems implies that clients should be screened for eating issues when entering treatment for substance use, and vice versa. Further, they suggest that integrated treatment should focus on the common contributors and reasons behind each of the behaviours (e.g., coping/relief from negative emotions and/or enhancement of positive emotions).

Due to the high prevalence of trauma in women experiencing co-occurring issues, incorporating a trauma-specific treatment approach to co-occurring mental health and substance use treatment is integral. Studies have found that providing women experiencing co-occurring issues with trauma-specific integrated treatment show decreases in substance use, mental health symptoms, and trauma related symptoms (Cocozza et al., 2005; Cusack, Morrissey & Ellis, 2008). There are currently a few

women-centered, trauma-focused treatment approaches that have shown to be effective in the literature. Examples of these are: Helping Women Recover and Beyond Trauma (Covington, 2003; 2008); Seeking Safety (Najavits, 2007); and Trauma Recovery and Empowerment Model (Harris, 1998).

One factor in providing trauma-specific treatment is the need for service providers to recognize many of the seemingly maladaptive behaviours of women, who have experienced trauma, are actually ways in which they are able to cope, adapt, and resist. Covington and colleagues (2008) argue that a central piece of women-centered, trauma-focused treatment involves ‘gender responsiveness’. This concept is defined as the creation of an environment:

through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's and girls' lives and is responsive to their strengths and challenges. They point out that traditional therapy generally reflects the dominant male culture. (p. 390)

Approaching treatment in this way requires the development and use of materials that are reflective of women's lives. Trauma-specific or informed approaches with women are focused on therapeutic relationships built on emphasizing safety, collaboration, and power sharing while focusing on strengths and empowerment (British Columbia Centre of Excellence for Women's Health, 2009). As trauma is such a large part of women's lives that belong to this population, it is important to design trauma-specific interventions and materials (Covington et al., 2008).

In a study done by Gatz et al. (2007) comparing trauma-informed integrated treatment (i.e., Seeking Safety) to a comparison group of residential substance use

treatment settings, it was found that improvement in distress symptoms and substance use was at least in part due to the integrated treatment approaches facilitation of new coping skills. This finding was corroborated by Covington and colleagues (2008) who demonstrated positive client outcomes, (e.g., reduction in symptoms associated with trauma and depression and decreased or discontinued substance use), in programs (i.e., Beyond Trauma) that focus on coping skills and emotional wellness.

A five-year multisite study done by The Substance Abuse and Mental Health Services Administration's (SAMHSA) entitled Women, Co-Occurring Disorders and Violence Study (WCDVS) found that increased, "empowerment and healing that comes when female clients are involved directly in their care and recovery" (Centre for Abuse and Treatment, 2009, p. 9). It further identified, "the need for comprehensive assessment that incorporates the history of trauma, physical and mental health needs, and the impact of co-occurring disorders on child care." (p. 9) Another study done using a trauma-informed integrated treatment approach, focusing on core concepts consisting of: resource coordination and crisis intervention; staff knowledgeable about trauma; holistic treatment of mental health, trauma, and substance use issues; and the involvement of consumers in service planning and provision (Morrissey et al., 2005, p. 1214), reported significant improvement in both PTSD and mental health symptoms in comparison to the other treatment condition. In addition to the core concepts used in the previous study, Huntington, Moses and Veysey (2005) found other concepts to be integral to integrated programs such as: outreach and engagement; screening and assessment; ongoing treatment activities; and parenting skills training.

Service Provider Narratives

There are very few studies that have explored service provider understanding

and/or experiences working with clients who have co-occurring mental health and substance use issues. There does not seem to be a clear picture of how clinicians working with this population understand and employ the knowledge and practices represented in current literature (Carey, Purnine, Maisto, Carey & Simons, 2000). Carey and colleagues (2000) conducted four focus groups with clinicians who were experienced in treating persons with co-occurring mental health and substance use issues. Most of the participants in this study, though working within the field of mental health, had pursued continuing education opportunities related to substance use interventions. Participants reported treatment approaches that highlighted: psycho-education; therapeutic rapport; and the need to be flexible in treatment approaches and goal formation. Although there were mixed perceptions regarding the role of abstinence in treatment, most participants conveyed abstinence as the preferred goal. However, they also reported views, beliefs and practices consistent with harm reduction approaches. This is consistent with the idea presented by Brown and Stewart (2007) suggesting that although health authorities formally support harm reduction strategies, substance use programs across Canada show bias towards abstinence-based approaches. It should also be noted that the Conservative government brought forth the National Anti-Drug Strategy (NADS) in 2007 that moved policies from prevention towards enforcement and control. This rejection of harm reduction policies contributes to both dominant discourse around substance use and ideas about treatment in addiction programs (i.e., addiction as a disease and abstinence as the primary treatment outcome) (Brown & Stewart, 2007).

Emerging from this research was a list of improved methods of treatment. Some of these included: staff that are cross-appointed and trained in both mental health and

substance use treatment interventions; qualified supervision; working ‘with’ approaches to engaging in the therapeutic relationship; treatment that incorporates psycho-education as well as flexible treatment modalities and goals; motivational interviewing techniques to reduce ambivalence; increase in the availability of external incentives for clients (e.g., safe, warm space, cup of coffee, access to food, etc.); and bureaucratic and institutional support for the development of integrated programming (Carey et al., 2000).

A study conducted by Ford-Gainer (2009), describing the lived experiences of mental health professionals, found that: ineffective treatment programs, lack of communication, lack of specialized educational training, and the influence of ‘problem’ client behaviour, all contributed to barriers in providing organizational integrated approaches. A study done by Halfpenny-Weir (2009), exploring mental health professionals experiences in working with co-occurring issues, found that care coordinators reported central themes relating to improving services which consisted of: using the cycle of change model in treatment planning; increasing service accountability and responsibility; understanding the nature of psychotic illness in screening and assessment; the importance of not making assumptions about substance use; and increasing levels of confidence in their clinical skills.

Jaynes (2008) interviewed social workers in mental health and addiction treatment settings in order to explore the modern identity of social work as a profession as well as their experiences related to the prospect of integrated treatment of co-occurring issues. Themes that arose out of this research involved: the scope of social work practice, public perceptions about the profession, autonomy, and compliance (i.e., social worker compliance to agency policies and procedures). Social workers in this study reported

beliefs around client's diminished ability to be autonomous and think for themselves due to their issues. This author suggests that client's right to self-determination was eliminated too hastily. Further, Jayne (2008) suggested the eradication of mandated treatment and revisiting notions regarding assumptions about client lives and behaviour. Social workers reported ideas regarding shared values between mental health and substance use fields, however several respondents reported concerns around compliance issues within their organizations (i.e., tired, overworked, and discouraged in relation to agency regulations and clerical work). Compliance in this study refers to, "bureaucratic compliance of an individual social worker to agency policies, or the agency's compliance with the larger fiscal and regulatory environment" (p. 74). Respondents also reported that there was not enough time in their current positions to pursue further education and research related to integrated treatment for mental health and substance use.

Barriers to Treatment

There are several barriers to treatment of individuals experiencing co-occurring mental health and substance use issues identified in the literature (Anthony, Taylor, & Raffo, 2011; Drake et al., 2001; Stewart, 2009; Todd et al., 2002). Drake et al. (2001) believes barriers fall into one of four categories: policy, program, clinical, or client and family. Policy related barriers are some of the most significant issues facing integrated treatment programs. Most of these issues related to organizational structure, financing, budgeting, licensing, and policy making (Drake et al., 2001). Stewart (2009) acknowledges that one of the most significant barriers in providing integrated services is that most of Canada's mental health and addiction services reside within separate health care programs. Indeed, substance use is often either ignored or used as exclusion criteria

in mental health treatment programs (Drake et al., 2001). Brown (2009) argues that due to fragmented treatment programs, trauma is often seen as a mental health issue rather than an issue to be explored in substance use work. She states that the pervasiveness of the medical model in the treatment of substance use and trauma allows for the relationship between the two to be an inferior consideration when determining intervention. This is due to dominant discourse around alcohol use in women that allows it to be separated from the context of women's lives. She asserts that this, in turn, allows for a culture where treatment not only does not address trauma history, but where women themselves are avoiding making those connections (p. 13).

Lack of recognition of co-occurring mental health and substance use issues within educational institutions as well as widespread parallel treatment approaches leave clinicians with a lack of training and ability to assess, work with, and treat the other issues (Drake et al., 2001; Stewart, 2009). This finding was substantiated through study done by Anthony, Taylor, and Raffo (2011) on community mental health practices in youth and young adults experiencing co-occurring substance use and mental issues. It found that service providers in mental health settings had problems with accurate assessment and diagnosis of substance use issues. They also felt their ability to provide interventions for substance use was limited in the current treatment context. Additionally, it can be argued that aside from clinician ability, programs lack clear service models, guidelines, and outcome measures necessary to implement and evaluate integrated services (Blakely & Dziadosz, 2007; Drake et al., 2001). Finally, client and family barriers are related to lack of information and adequate service availability (Drake et al., 2001). There are not enough psychoeducational components of programs specifically

directed at co-occurring mental health and substance use issues for clients and families.

Clients may tend to minimize or deny substance use to family and/or clinicians. They also may believe that substance use acts as a way of coping or decreasing stress. These factors may influence client motivation in seeking treatment for substance use, which in turn, can affect treatment for mental health (Drake et al., 2001).

Women also face unique barriers to treatment when compared to men. As previously stated, women experience higher rates of burden in their lives and therefore are not afforded adequate treatment options that meet their complex needs (i.e., childcare, fear of child welfare, pregnancy, work conflict, stigma, sexism, diversity and cultural differences, transportation, trauma, safety due to intimate partner violence or unsafe housing, etc.) (Brown, 2009; Brown & Stewart, 2008). These issues need to be addressed when providing treatment for women who experience co-occurring mental health and substance use in order to reduce the affects of stigmatization, self-blame, minimization, and ambivalence (Brown, 2009).

CHAPTER THREE: METHODOLOGY

This chapter provides a detailed overview of the methodology and research design used in this study. It first outlines the research question and objectives of the study then goes on to outline the research design as well as providing a rational for why it was chosen. It further outlines the method used for participant sampling, data collection, and data analysis. This section also provided an overview of how confidentiality and anonymity was maintained as well as a framework for ethical considerations and potential benefits.

Research Question and Objectives

This research explored the following question: how do service providers in Nova Scotia understand and work with co-occurring mental health and substance use issues among women. The primary objectives in this study are:

1. To gain insight into service provider narratives of their experiences in working with co-occurring mental health and substance use among women.
2. To gain a better understanding of how service providers understand the relationship between co-occurring mental health and substance use issues among women.
3. To gain a better understanding of their theoretical frameworks and subsequent intervention strategies in working with this co-occurrence.
4. To explore how their understanding of the relationship is reflected in their approaches to working with co-occurring mental health and substance use issues.

Research Design

This study utilized a qualitative research approach. Creswell (1998) defines qualitative research as:

an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The research builds a complex, holistic pictures, analyzes words, reports detailed views of informants, and conducted the study in natural setting (p. 15).

Qualitative research is primarily concerned with description and interpretation. These concepts are intertwined in order to help us derive meaning from experience (Denzin & Lincoln, 2000). In qualitative mental health research, narrative inquiry has been previously demonstrated as a helpful approach in gaining information about individual experiences (Avdi, 2008; Avdi & Georgaca, 2009; Brown, 2012; Harper & Thompson, 2012; Josselson, 2011; Murray & Sargeant, 2012; Wells, 2011). In discussing narrative research, Squire (2008) states:

Most often, perhaps, we frame our research in terms of narrative because we believe that by doing so we are able to see different and sometimes contradictory layers of meaning, to bring them into useful dialogue with each other, and to understand more about individual and social change. By focusing on narrative, we are able to investigate, not just how stories are structured and the ways in which they work, but also who produces them and by what means, the mechanisms by which they are consumed, and how narratives are silenced, contested or accepted. All these areas of inquiry can help us describe, understand and even explain important aspects of the world. (p. 5)

Narrative inquiry operates within the understanding that, “people live and/or understand their lives in storied forms, connecting events in the manner of a plot that has a beginning, middle, and end points” (Josselson, 2011, p. 224). In discussing narrative inquiry in mental health research, Murray and Sargeant (2012) note:

Narratives are also told in context. Thus, we are not telling stories in a vacuum but rather to another person. The context of storytelling is therefore important in understanding the particular shape of the narrative, especially when interpreting the narrative account obtained in an interview. (p. 165)

Given that meaning is culturally, contextually and socially constructed through the use of language and discourse; narrative research generates meaning through the participants understanding of their experiences and interpretation of these stories by the researcher (Bruner, 1990; Josselson, 2011).

From an epistemological standpoint, narrative research relies on notions of multiple truths, with not all truths given the same amount of power and privilege. Narratives often encompass dominant notions of socially constructed “truths” that need to be explored and unpacked (Josselson, 2011). Brown and Augusta-Scott (2007, p. xi) assert that, “to not unpack, or deconstruct, dominant stories is to leave dominant social discourses and social relations of power intact.” Narrative research relies on process of mutual storytelling and restorying narrative accounts (Connelly & Clandinin, 1990; Creswel, 2013). Riessman and Quinney (2005) suggest that narrative researchers might focus on these questions when interpreting narrative accounts:

For whom was *this* story constructed, how was it made, and for what purpose?

What cultural resources does it draw on – take for granted? What does it

accomplish? Are there gaps and inconsistencies that might suggest alternative counter-narratives? (p. 393)

This research was continually looking for ways in which the stories of service users both reflect dominant discourses and provide counterstories outside of dominant narratives. Narrative Inquiry seemed the most appropriate choice for this study in order to gain an in depth understanding of service provider's experiences in working with co-occurring mental health and substance use issues among women.

Participants and Sampling

The participant sample consisted of six service providers who work in the fields of health and wellness (primarily mental health and/or addictions) in Nova Scotia (originally seven interviews were completed however one participant was excluded due to not adequately meeting the criteria for participation). The service providers in this study consisted of masters level social workers employed in both formal and informal Community-Based and Intensive Treatment service settings who are engaged in counselling or therapeutic work. Master level social workers were specifically chosen as opposed to bachelor level social workers (BSW) because the master's level curriculum provides, "knowledge and skills in research/scholarship, professional leadership, social work supervision and advanced practice and/or areas of specialization" (CASWE-ACFTS, 2013, p.10). This is in contrast to the more generalized curriculum in BSW programs.

Social workers were chosen for this sample as opposed to other disciplines prominent in this field for a few specific reasons. The first is that due to the small sample size, keeping a relatively homogeneous sample of service providers was beneficial when

analyzing the data in order to reduce limitations associated with differing education levels or discipline perspectives. This sample was also more accessible given my own discipline as a social worker and snowball sampling method of recruitment. Further, social workers play a dominant role in both mental health and addictions services in Canada and therefore provide excellent sample for this area of research (Health Canada, 2002).

A purposive criterion sampling method was utilized in this study with inclusion criteria consisting of master's level social workers, who have at least informally, worked with women experiencing both mental health and substance use issues concurrently (i.e., service providers do not necessarily have to be employed in a program that is designed for women with co-occurring issues however it does have to be a population they see in their practice). Recruitment was primarily done through a snowball sampling method, where the initial participants consisted of contacts in the field and subsequent participants were recruited through referral. No other methods of recruitment were needed in this study.

Data Collection

Data was collected through qualitative methods in order to gain an understanding of individual experiences and narratives. Prior to the beginning the interview, participants were asked to fill out a short demographic questionnaire that looks at identity, age, education, and employment (see Appendix C: Demographic Questionnaire). I engaged in an approximately one-hour in-depth, semi-structured narrative interview with each participant (see Appendix D: Interview Guide). This method of data collection has been previously recommended as an effective method for narrative inquiry (Jovchelovitch & Bauer, 2000). Interviews took place in person and were conducted in a space of the

participant's choice (i.e., participant office or scheduled meeting room at the Dalhousie W. K. Kellogg Health Sciences Library). Jovchelovitch and Bauer (2000) suggest that, "the narrative interview envisages a setting that encourages and stimulates an interviewee to tell a story about some significant event in their life and social context" (p. 2).

Participant experiences and meanings were viewed through a variety of concepts such as: agency/organization, program, professional designation, education, field of work, time spent in field, geographical location, gender, sexual identity/ orientation, age, ethnicity, and race. Including these concepts in the analysis was helpful in interpreting and making sense of the data.

An iterative process was utilized in conducting the interviews with the interview schedule prepared prior to collecting data. Interview questions fell under four main topic areas (i.e., participants narrative accounts of experience; participant understanding of the relationship between co-occurring mental health and substance use; theoretical framework and intervention approaches to working with women who experience co-occurring mental health and substance use; and barriers they experience in working effectively with women who experience co-occurring mental health and substance use issues). The interview schedule was used only as a guide to facilitate the exploration of participant meanings and narratives. It provided the ability to concentrate on the interview as well as cover specific themes. The interviews were audio-recorded using the digital voice recording SuperNote and transcribed into text using F5 Transcription and stored in Microsoft Word for Mac 2011 documents.

Data Analysis

The narrative analysis focused on both the content and structure of service user stories (Josselson, 2011). This narrative research employed both a thematic analysis (Braun & Clarke, 2006; Riessman, 2005) and a discursive analysis (McMullen, 2011; Wells, 2011; White, 2007). These approaches supported the exploration of thematic categories and discursive units. This analysis continuously placed emphasis on the whole account (i.e., how the parts contribute to the entire meaning). Both of these approaches are prevalent among narrative research (Creswell, 2013; Josselson, 2011; Wells, 2011).

Thematic analysis is useful as it has the ability to be used across a wide range of theoretical and epistemological research approaches. This particular research is firmly grounded in a constructionist perspective, and therefore thematic analysis aims to interpret participant accounts in terms of socio-cultural contexts (Braun & Clarke, 2006; Brown, 2013). Thematic analysis is primarily concerned with interpreting the data into thematic categories by “identifying, analysing, and reporting patterns (themes)” (Braun & Clarke, 2006, p. 6). These categories allow for the interpretation of exactly what was spoken in the narrative and provide a means for more in depth discussion of narrative meanings (Creswell, 2013).

In accordance with Braun and Clarke (2006), a six-phase process of thematic analysis was used that describes both the story and the emerging themes: Phase 1: familiarizing one self with the data by reviewing transcripts several times; Phase 2: generating initial codes; Phase 3: searching for themes; Phase 4: reviewing themes across entire data set (i.e., eliminate, collapse, and separate themes); Phase 5: defining and naming themes; and Phase 6: producing the report. Continuous attention was paid to the

gaps and contradictions that exist within service provider accounts of experiences in order to produce counter-narratives.

After the initial generation of themes describing in-depth narrative accounts, a discursive analysis began that allowed for service provider narratives to be contextualized into the broader social constructs of mental health and substance use among women. Wells (2011) defines discourse analysis as:

A family of approaches to talk and text that emphasizes its broad meaning or the cultural discourses upon which it draws... thus, investigators are concerned with not only how individuals produce discourse but also how they are products of discourse. (p. 8)

McMullen (2011) suggests that poststructuralist methods of discourse analysis are concerned with discourse as a construct that helps people make sense of meaning.

Following the initial analysis, the discursive process began with the creation of questions and concerns arising out of what was found to be most interesting. Following this, any potential relevant material was drawn out in relation to the questions and concerns. Once everything potentially relevant was selected out, a more in-depth analysis began that worked to refine the excluded pieces that are not relevant to the research question and objectives. McMullen (2011) suggests that:

Further work with those parts selected for in-depth and intensive analysis involves an iterative cycling between specifying and addressing the question(s) of investigation. Questions often take the form of "How is X constructed?", "What is being done and how is it being done?", or "What are the functions and consequences of what is being done?" (p. 208)

With continuous attention paid to “context and variability” (p. 208) the analysis produced a set of interpretations. Discursive analysis is never fully complete as questions and focus may continually be altered through the research process with further exploration into the data. Throughout both the thematic and discursive processes, direct quotes that highlighted participant meanings were continually pulled out of the transcripts.

Using both thematic and discursive approaches to analysis allowed for the construction of descriptive narratives of events as well as what the events have meant to the participants. Braun and Clarke (2006) suggest that using a thematic approach allows the researcher to move beyond the surface accounts of participant narratives and provide “thick descriptions” of the data set (p. 37). These thick descriptions provided the means necessary to begin to unpack dominant service provider stories. The discursive data analysis allowed for further interpretation of service provider stories in terms of contextualizing them through dominant social discourse and structures that shape their understandings of co-occurring mental health and substance use among women (McMullen, 2011; Wells, 2011). Discourse analysis has the ability to emphasize service provider positionality and conceptual approaches within current societal systems. This allowed for the formation of counter-narratives that are already being produced through service provider accounts as well as counter-narratives not currently present that could potentially be helpful (i.e., in terms of politicization, education, and policy changes).

Confidentiality and Anonymity

Data collected was of a relatively personal and sensitive nature including contact information, demographics, and participant experiences in work contexts. Prior to beginning the interview, participants were asked to read and sign a consent form

outlining in detail the study as well as any ethical considerations (see Appendix A: Informed Consent Form). The data was collected using a digital voice recorder, which was then transcribed onto a computer. Once transcribed, the data was erased from the digital voice recorder. This electronic data was stored on a password protected secure server. Hard data was kept under an identifying code known only to the primary researcher and kept in a locked filing cabinet. The identifying code was then linked to a pseudonym used to differentiate between participants in the final report. Personal contact information and informed consent forms were kept separate from the hard data and locked in a separate area of the filing cabinet to ensure that the identifying information cannot be linked with the interview content. The data will be retained by the research team for five years after the release of the final report, after which, all the physical data will be shredded and electronic data will be deleted.

It was not entirely possible to ensure total anonymity of the participants. I know the identity of the participants during the interviews and though the interviews were given a code number, I have access to each participants identifying code. Further, due to the snowball sampling method, other participants may have been aware of whether or not their colleagues were referred and/or participated in the study. To try to address issues of anonymity, I was the only person who had access to identifying information of the participants. Contact information was kept separately from all interview transcripts. Participants were interviewed in their place of work or in a space where they were comfortable. Additionally, after the interviews were transcribed, I removed all information obtained during the interview that may be identifying from the transcript (e.g., may include name, age, gender identity, race, department, service program, etc.).

Only my supervisor and I had access to the interview transcripts in order to eliminate the risk of participants being identified through their interview content. Participants will be notified during the informed consent process of the “duty to disclose” and in the event a disclosure is made, the researcher will follow all legal requirements.

Ethical Issues

There were only a few potential ethical issues that were anticipated within this research. As the population is not particularly vulnerable the level of risk was relatively low. Participants could have felt some discomfort or emotional distress in discussing certain topics in relation to their understanding or practice approaches in co-occurring mental health and substance use issues, however this was unlikely as most of the individuals interviewed will have some level of experience or expertise in this area. Participants could have left the interviews feeling as if they have shared too much personal or organizational information, and perhaps this could have caused some discomfort or distress at a later point in time. Participants could also have been concerned with confidentiality and anonymity due to sharing information that may affect job security, personal and/or organizational reputation.

In order to minimize risks as much as possible, I made every effort to treat participants with respect and dignity at all times as well as exercising genuine curiosity and sensitivity to their life experiences. The interview did not consist of questions regarding participant personal experiences or life situations. Participants were only asked questions related to their theoretical and practical understanding of their field. I also made an effort to check-in with participants throughout the interview about their comfort level and if they wanted to continue. Additionally, at the end of every interview, I conducted a

debriefing procedure interview that was unrecorded, where participants were given time to debrief and discuss how the interview felt for them. Participants were also able to withdraw from the study at any point and withdraw their material from the study if they so desired. No participants chose to withdraw from the study.

There are also several potential benefits that could arise out of this study. This study contributes to a growing body of research on co-occurring mental health and substance use. More specifically, it addresses the lack of research and information on this topic for Nova Scotia in relation to co-occurring issues in women. This research also contributes to the discussion on intervention approaches for co-occurring mental health and substance use issues specifically among women. Further, participants in this study as well as other community and health care professionals within this field may gain some insight into how their colleagues understand and work with these issues. This insight could spark agency discussion around education, training, and program development. Finally, this study may provide some front line knowledge into how the Mental Health and Addiction Strategy in Nova Scotia is being implemented and carried out.

CHAPTER FOUR: FINDINGS

This chapter provides an in-depth review of the findings from the narrative interviews conducted with service providers working with women who experience co-occurring mental health and substance use issues. The interview questions fell under four primary topic areas relating to: participants narrative accounts of their past work experiences and development of ideology; participant understanding of the relationship between co-occurring mental health and substance use; theoretical framework and practical approaches to working with women who experience co-occurring mental health and substance use; and barriers they experience in their practice as well as the barriers women experience in seeking services. The overarching purpose of the interviews was to gain insight into how these clinicians understand and work with co-occurring mental health and substance use issues in women. The interviews produced thick descriptions of the data set, which has allowed for the construction of themes to emerge out of the analysis. The chapter will begin with a participant profile that provides some relevant demographic information and will follow with an overview of the themes emerging that describe service providers' experiences and participation in dominant discourses as well as counterstories of reflection and resistance to dominant narratives.

Descriptive Overview of Participants

The participants in this study were a fairly homogenous group. There were six female participants, ranging in ages from 32 to 53, all who identified as being Caucasian or of European descent, living and working in Halifax Regional Municipality. Initially there were seven participants however one participant was excluded due to lack of practical experience working with women who experience co-occurring mental health

and substance use issues. All of the participants had Master of Social Work (MSW) level educations and ranged in field experience from 3 to 23 years (five of the participants had 10 or more years of experience). One participant identified with an LGBTQ identity, which was excluded from the demographic table in order to protect confidentiality. Three of the participants cited specific training relevant to their field of practice. This information is displayed below in Table 1.

| Participant | Age | Education | Field Experience (Years) | Relevant Training | Field of Employment |
|--------------------|------------|------------------|---------------------------------|------------------------------------|----------------------------|
| Alicia | 32 | MSW | 3 | CBT, Mindfulness | Mental Health (Crisis) |
| Hannah | 35 | MSW | 13 | Mindfulness, Feminist Therapy | Mental Health (GB) |
| Jacqueline | 47 | MSW | 15 | N/A | Addiction Services (GB) |
| Maya | 53 | MSW | 23 | Motivational Interviewing | Addiction Services |
| Melanie | 35 | MSW | 10 | Workshops/Professional Development | Community (GB) |
| Alyssa | 40 | MSW | 14 | Workshops/Professional | Mental Health (GB) |

Table 1: Demographic Information – Age, Education, Experience, Relevant Training, and Field of Employment

* Due to participant confidentiality employment specific information was not included (i.e., Community-Based versus In-Treatment)

** GB refers to social workers that are working in or have recently worked in gender-based programs/organizations that provide services to women only.

All of the participants except for one have worked or were currently working (at the time of the interview) in Mental Health or Addictions Services in Nova Scotia. Two participants were working in Mental Health and two were working at Addictions Services during the time of the interview. At the time of the interview, one participant was working in Women's Mental Health at another formal institution outside of the Nova Scotia Health Authority and one was working in a community-based women's

organization doing case management and clinical work with marginally housed women. Four out of six participants were currently or recently working in gender-specific programming. Interestingly enough, three out of six participants have a past history of working at Avalon Sexual Assault Centre (over the past 25 years), which is a feminist based service in the community providing counselling to women who have experienced sexualized violence.

Narrative Interviews: Experiences of Service Provision

It is first and foremost worth mentioning that all of the women interviewed discussed their engagement in their work with passion, knowledge, and enthusiasm. Regardless of their ideological understanding or theoretical approaches to practice, they demonstrated a genuine commitment to providing the best possible services to women with co-occurring issues that they were capable of, as well as a sincere desire to offer support and advocacy. All of the participants were able to identify at least some understanding of the dominant discourses and oppressive social structures women face that are struggling with these issues and they provided a multitude of stories outlining their own resistance to dominant institutional ideology. Interviewing, exploring, and unpacking the experiences of these clinicians was incredibly valuable, not only in deepening the narratives in the current study, but also in adding to my own practical approaches in working with women.

All of the participants identified the relationship between mental health, substance use, and trauma and the importance of working with co-occurring issues simultaneously. Many of the clinicians interviewed described practice approaches that could be considered eclectic in nature, drawing on many different approaches ranging from

feminist-based practice to cognitive behavioural therapy to mindfulness to solution-focused therapy. The participants in this study identified a multitude of institutional and organization barriers that both service providers and women face in conducting and accessing treatment for mental health and substance use issues. Out of their narratives, five predominant themes that arose that will be described in detail below: (1) Service Provider Understanding of the Relationship Between Mental Health and Substance Use; (2) Connections Between Theory and Practice; (3) Development and Description of Ideology; (4) Barriers to Service Provision; and (5) Recommendations For Change.

Service Provider Understandings of the Relationship

It has been widely documented that a strong and significant relationship exists between mental health and substance use (Skinner, 2005). Service provider narratives outlining their understanding of the relationship were representative of the complexities existing in the literature. Consistent with interactional models presented by Skinner (2005), there was cohesion across participant narratives around mental health and substance use not existing as separate issues but rather interacting, interconnecting and intersecting with one another. Most of the participants described commonalities in terms of the issues they are seeing with women in their practice. For mental health, women who are accessing services are generally presenting with anxiety, depression, and what was often referred to as ‘personality disorders.’ The most common substance use issues are alcohol, marijuana, opiates, and prescription pill misuse. Most participants reported the co-occurrence of any number of substances (primarily alcohol but also marijuana, prescription pill use, opiates, and cocaine) with anxiety, depression, and ‘personality’

disorders'. All participants reported the commonality of the co-occurrence of trauma with mental health and substance use.

In describing the relationship between mental health and substance use, Jacqueline acknowledges that:

I see substance use as again, that relationship with mental health is substance use impacts your mental heath and your mental health impacts your substance use. So I see them as being very much together. It is sometimes hard to separate.

Discussed in more detail later, Hannah begins the conversation around common experiences of women who have co-occurring issues:

...you know at addiction's, it was trauma mental health, which you know... was sort of the paradigm that I work with... I don't actually see any of these things as sort of... I don't see them as sort of...[separate]... and I think they tend to be all pretty interrelated so... so yeah, when I'm working with women and the different places that I've been at, it's kind of like depression, anxiety, trauma... eating stuff, self-harm, substance use... all of those things tend to kind of like intermingle.

Maya describes how even though our institutional systems have separated them, her experience working with clients has not been reflective of this separation:

You know, we sort of separated them because we have these schools that, addictions kind of grew up this way and mental health has come from medicine and addictions kind of come more from the community, so that's sort of the way it is. But I don't really – I don't ever see anybody who has ever come in my office

and said that there might be an issue, that it hasn't affected their mental health somehow. So... they're really not two separate things.

Maya even suggests that if a woman has a substance use issue, she also has a mental health issue given that any degree of harmful involvement with substance use will affect one's mental health:

Well, if you have an addictions issue, you have a mental health problem, in my mind, right. Because, you can't, you know, and – and – and it can be anywhere from – from, a full blown severe addiction to harmfully involved right... So we talk about harmful involvement... But even if you are harmfully involved to the point that it's affecting something in your life, that's going to affect your mental health. That's going to affect how you feel. So... And if it affects how you feel to the point where you become severely depressed – you can't get out of bed. You can't do anything with your life. All you want to do is drink. I mean, I think they're always kind of together.

Although participant narratives suggest that there is an overarching belief that substance use and mental health are related, there were some discrepancies around how they were related. Often participants were questioning the exact nature of the relationship and how mental health and substance use actually interact with one another. Reflective of a bidirectional model (Mueser, Drank, & Wallach, 1998; Skinner, 2005), Alicia and Alyssa both spoke to the chicken and the egg analogy about which one comes first:

It's like that chicken and the egg argument... There's tons of, and that's the thing, I don't think anyone has a real good handle on being able to, kind of, make a nice

blanket statement around that... that it's necessarily one you know as the cause of the other. (Alicia)

Maya spoke to the conversations coming up with clients in practice with them asking questions about cause and effect, "was I depressed and that's why I drank, or was I drinking and then that lead to the depression?" Most of the participants acknowledged that although you are able to experience a mental health issue without the experience of substance use, you are unlikely to experience a substance use issue without a mental health component.

Their accounts were often contradictory throughout the interviews, reflecting the complex nature of understanding the relationship between mental health and substance use. An example of this was Maya's explanation of how, "more and more we're talking about addictions as... were understanding addictions as a brain disease." She suggests that there has been an evolution over the last 20 years, initially moving away from this view and argues that research is moving us back towards the disease-oriented model of 'addiction'. This indicates Addiction Services in Nova Scotia could be moving towards viewing harmful involvement with substance use in a similar manner as mental health. Brown and Stewart (2007) warn against this simplification of substance use stating, "when alcohol addiction is considered a primary disease, alcohol use as a secondary response to trauma, anxiety or depression is entirely discounted" (p. 432).

Given that individual experiences are multi-storied, Maya also provides a counterstory of substance use as a symptom or a response:

Well they can be. Sure. For some people, oh yea, for some people they are symptoms of a lot of things. Right... that might be, you know, severe depression,

to... to... umm... incidental things, like my husband left me and I'm lonely. I'm all alone for the first time in my life. You know, my mother died. My... specially for women... if we're talking about women, and what we do know about women is that there's a later onset to addiction. And it's more around critical incidences in people's life. Right. So that kind of separation, loss, grieving, parents - problems with children. And as well as, a history of being abused and being marginalized because we're women.

Although there has been evidence that women experience a later onset of substance use issues or problem gambling (see Fattore, Felis, Fadda & Fratta, 2014; Greenfield, Back, Lawson & Brady, 2010), the gender gap has been narrowing significantly over the past 50 years for substance use. Though women have been found to develop substance use related problems more quickly than men after initiation of use (Greenfield et al., 2010).

Participants seemed less conflicted about biological factors involved with mental health as opposed to substance use (i.e., there was more of an acceptance that mental health may have more of a biological etiology). All of the participants spoke to potential genetic predispositions or biochemical involvement with mental health, especially severe and persistent mental health concerns (e.g., experiences of psychosis, schizophrenia, etc.). Alyssa highlights this by stating:

So you look at sort of the nature-nurture experience, right. So you may have women who are predisposed genetically to mental health issues but then they have never had anyone who has kind of cared for them or nurtured them or made them feel important or valued so over time of course, umm, they develop, you know, they... have this inability to, kind of, cope with stress and life. Or manage

their own emotions, or develop healthy relationships. And it just worsens and worsens over time and they develop all kinds of symptoms.

Although Hannah stated that it cannot be separate from person-in-environment:

I'm not saying that people don't have a predisposition to something, you know... but my understanding of mental health... I haven't met anyone who was really struggling and hasn't had really bad things happen to them.

In general, participants told more conflicting stories about their understanding of the causes substance use.

Both/And Interpretations

Many of the participants constructed a both/and approach to her interpretation of the relationship between mental health and substance use, where there is a consideration of both biological and environmental factors. Most participants brought up a version of the nature versus nurture debate for both mental health and substance use, which was continuously explored, revisited, and revised throughout their narratives. Hannah discusses moving from working at Addictions to Mental Health and confirming that individuals in both areas are struggling with a number of issues related to their historical contexts and current environments (as opposed to the pathological descriptions provided on their referrals).

...all of these things are listed as pathology in a way that would suggest that all of these people are just sort of like are born this way... no matter what happens to them their going to be... and I'm not saying that people don't have a predisposition to something, you know... but my understanding of mental health... it reinforces what my thinking was already but when I got there I just

realized, oh okay well...I haven't met anyone who was really struggling and hasn't had really bad things happen to them.

Even though all of the participants acknowledged that there could be a biochemical or genetic predisposition to mental health and half spoke to the possibility of this being a factor in substance use issues (Alyssa, Maya, and Jacqueline), all of the participants described narratives around the influence of environment and experience. Jacqueline describes this by stating:

I see all of us having within us, an ability to have substance use problems. But some because of their biology may have a predisposition or a risk... others because of our social environments may also have a predisposition or a risk to come into problems with mental health and with substance use. So I am always looking at the both of them together when I am working with women. But I am also... I try to take a very keen interest in looking at those social aspects of someone's lives that can really increase the risk.

Secondary Response

Many of the participants understood substance use as a secondary response or a method of coping with mental health, trauma or other environmental and social factors. Hannah provides a clear statement around substance use as a secondary response:

...so I have theories about substance use, you know... I have a very clear party line on substance use too which is that it's self-medicating. I see substance use just like pure and simple, it's a symptom of something else. I never met anyone who like didn't have a reason to use or drink.

She goes on to explain that both substance use and mental health issues can be secondary responses to something else going on in the individual's life:

...substance use tends to be one way of coping with other bad things that have happened to you. So... you know... I saw this all the time at Addictions and sometimes I see it at Mental Health too, which is just sort of like, there would be this triangle of coping, which was just sort of like: drinking, cutting, food stuff... you know... there would sort of like depression and anxiety or whatever... and people would kind of like... bob back and forth between them.

Many participants described substance use as a behaviour, a mechanism for coping or 'self-medicating' or a response to trauma or other stressors. Jacqueline explains substance use in terms of coping with stressors and as a way to care for themselves:

I see substance use... again as being a behaviour that we use... I use... just like any other behaviour to help us cope with stresses and demands and I guess the two can co-exist... But people tend to... at least folks I work with, tend to use substances as a way to cope with challenges... if it is too much stress in their lives, or moods that they have for whatever reason, or not feeling like they belong, they will use substances to help care for themselves the best way they know how.

Trauma

The findings demonstrated that one of the most dominant stories being told about their understandings of the relationship between mental health and substance use in women was the relationship with trauma. Many of the participants maintained that most of the women coming through their offices has a history of trauma experiences:

But I see them as really... you know... in the women's population with addictions, it was all trauma basically... Trauma and mental health stuff right... depressed and anxious, self-medicating with whatever it was they using, you know... (Hannah)

...for women and co-occurring mental health issues... I would have to say it is trauma. Like I would really have to say [that] a significant majority of women who come in to see me or you know, through the course of our conversations it usually comes up that there has been a traumatic event or a series of traumatic events or relationships or events within relationships that they have experienced the two together. (Jacqueline)

So we work with a lot of women with trauma backgrounds. And... umm, a lot of the women we work with who have co-occurring mental health and addictions, umm, that seems to also co-occur with the trauma background. So people using substances in order to cope with trauma effects that have also led to depression and anxiety. (Melanie)

It was also common for participants to describe mental health, substance use, and trauma within the context of other behaviours such as eating issues and self-harm. This relationship has been well documented in the literature around co-occurring issues in women (Stewart & Brown, 2007a; 2007b; Stewart, Brown, Devoulyte, Theakston & Larsen, 2006). Regardless of individual service provider accounts of their understanding of the relationship between substance use and mental health, it was clear that their narratives were reflective of the literature suggesting a multitude of factors and models theorizing the relationship between the two. Service provider understanding of the

relationship was often reflected in their accounts of theory and practice which will be discussed in the next section.

Connections Between Theory and Practice

Participants provided in-depth descriptions and examples of their theory and practice. All of the participants described numerous theoretical and practical frameworks, which could be interpreted as them having an eclectic approach to their practice. Given that participants provided such a diverse range of practical and theoretical approaches, it was helpful to simplify them into models (of practice), perspectives, and theories. Payne (2005) describes models as, “principles and patterns of activity which give practice consistency” (p. 5). Models offer a description of what is going on during service provision. Perspectives are outlined as ideas, beliefs, values and worldviews existing in one’s practical approaches. Payne (2005) states that, “perspectives help you to think about what is happening in an organized way” (p. 5). Finally theories, offer an explanation for, “why an action results in or causes particular consequences and identifies the circumstances in which it does so” (Payne, 2005, p. 5). Participant accounts of their theoretical and practical frameworks as well as their perspectives informing their practice are outlined below in Table 2.

| Participant | Practice Models | Perspectives | Theories |
|-------------|---|----------------------|--|
| Alicia | Brief Solution-Focused Therapy Dialectical Behavioural Therapy Strengths-Based Mindfulness Cognitive Behavioural Therapy | Feminist | Feminist Theory Cognitive Behavioural |
| Hannah | Feminist Therapy Mindfulness Motivational Interviewing Relaxation Narrative Therapy Cognitive Behavioural Therapy | Feminist Buddhist | Critical Anti-Oppressive Narrative Feminist Theory |
| Jacqueline | Seeking Safety Mind-Body-Medicine Relaxation Mindfulness Motivational Interviewing Solution-Focused Therapy Strengths-Based Narrative Therapy | Feminist Buddhist | Empowerment Cognitive Behavioural Narrative Social Constructionism Critical Anti-Oppressive |
| Maya | Structured Relapse Prevention Community Reinforcement Approach Motivational Interviewing Dialectical Behavioural Therapy Cognitive Behavioural Therapy Strengths-Based Seeking Safety | Individualism | Cognitive Behavioural |
| Melanie | Client-Centered Strengths-Based Solution-Focused Harm Reduction | Feminist | N/A |
| Alyssa | Cognitive Behavioural Therapy Dialectical Behavioural Therapy Interpersonal Psychotherapy Strengths-Based | Humanist Feminist | Cognitive Behavioural Empowerment |

Table 2. Overview of Models, Perspectives, and Theories Associated With Practice

* This table provides a snapshot of participant narrative accounts of their models, perspectives, and theories related to their practice of social work.

** All of the models, perspectives, and theories were identified by participants, except for critical theory and anti-oppressive theory. These were assigned given their responses.

*** Not all participants were able to identify the difference between practice models, perspectives, and theories. These were reorganized or recategorized based on the definitions of each offered by Payne (2005).

Eclecticism

General social work practice is often referred to as eclectic (Payne, 2005), however finding a definition of eclecticism has proven difficult. In general, eclecticism refers to the use of a number of theories and practical approaches in one's practice in order to provide the most effective treatment approach for each specific client situation (Jayaratne, 1978; Payne, 2005). Participants drew on a number of practical approaches, the most common being cognitive-behavioural and strength based approaches. Maya spoke of the usefulness of strength-based approaches in her work and how they can lead to behaviour change:

Doing that kind of strength-based work, even years ago, women just like reacted so, so strongly to it. To actually, if somebody, like a professional thought they had strengths, even if they didn't, then they would actually start believing it. And like, go act on some of those strengths... which, would help and start changing some of those behaviours.

Jacqueline spoke to her use of cognitive behavioural approaches in practice but provided a counterstory in terms of understanding social contexts and dominant discourse:

So I guess I do use cognitive behavioural I'd say, but again I am very mindful that most peoples beliefs that may have come from a social context. We're taught our beliefs.

Participants also commonly spoke to other approaches such as motivational interviewing, mindfulness, solution-focused, narrative therapy, dialectical behavioural therapy, client-centered approaches, and Seeking Safety. It should be noted that the only participant who

spoke to the use of harm-reduction in her practice was Melanie, and she is working in a community-based organization.

Many participants also spoke to the importance of evidence-based approaches when creating their practical frameworks as well as the frameworks of the organization.

Maya spoke to this by stating:

...so we're always using in addictions, cognitive behavioural types of approaches.

So, umm, we use, mindfulness works really well, and so we use Structured Relapse Prevention. I keep looking over here {looking to bookcase} cause I usually have some books but they're gone. So this top book, which I didn't mention before, is a Community Reinforcement Approach. It's a really great, sort of, behavioural way of working with people with drug and alcohol problems.

That's the functional analysis - came from that... Motivational interviewing as a way of being with people is - is a given. Right. The Community Reinforcement Approach as well as CBT, are the top three evidence-based best practices with anybody who has addictions problems. Coming out of the CBT and CRA, are sort of, relapse prevention work. Very cognitive behavioural.

Other participants critiqued the use of evidence-based approaches. When asked if she uses evidence-based approaches in her practice, Hannah stated:

Oh use them in my practice? ...not in the way that their taught. I don't know if you have done any solution focused or CBT or you know... What I find is that, especially at Addictions, motivational interviewing is like all the rage now... [It is] basic like client centered... really straight forward, what I would consider just like talking to somebody one-on-one. It's like this big thing now. So... you

know... a lot of those you know, so when I did motivational interviewing, this is just another way of framing really basic, what I figure is um... you could call it feminist, you could call it a lot of things I guess, but just like stuff that was already in there... the number one determining factor about whether therapy is effective is rapport. If somebody doesn't like you, they will not talk to you. That gets left out of those conversations. How are you going to establish that relationship with someone - what does that look like... So when we're talking about evidence-based, like oh CBT or whatever... and I am just still like if you're annoying with your sheets then... you know... they are not having it. Clients are not having it. They won't necessarily tell you - they just won't come back.

She went on to acknowledge an understanding of a potential motivator for organizations to implement evidence-based approaches, related to the importance of having a grounded theoretical and ideological framework of practice.

You have to have a reason for why you are doing what your doing. There is lots of therapy going on out there that... and I get why the system is so focused on evidence-based because they are aware of the fact that there is a lot of shit that goes on... that's really like... 'oh god'... I get why the system is so focused on evidence-based practice. I think that we should always be trying to ensure that we are doing something that is helpful.

This is congruent with Payne's (2005) assertion that eclecticism should be approached "consistently, in a planned way" (p. 31). Taking ideas from different places without having a firm understanding of the beliefs, values, methods and objectives behind them can be dangerous and confusing in therapeutic practice (Payne, 2005, p. 31).

Although only a few of the participants specifically mentioned ‘trauma-informed’ or ‘trauma-specific’ practice models (i.e., Seeking Safety), other than feminist based work, when asked about their practice approaches, all of the participants provided a consistent narrative in terms of how trauma should be used to inform the work they are doing with women who experience co-occurring issues. Hannah describes the importance of factoring in trauma when looking at someone’s ‘symptoms’ or how they are responding:

...a certain set of symptoms would get sort of talked about... [when actually] this is about trauma and how you've been socialized. Umm... because you're not... dealing with just like the set of symptoms the person is struggling with... you're also dealing with how they make sense of that and how they approach it.

She later explains trauma in the context of her therapeutic practice:

I grew up or came of age as a therapist in the context of trauma. Which is like... and trauma if it is at all feminist is coming from a place that there are reasons for the things that are happening to you. You are behaving or responding in this way for a reason. There is a reason. So... the other thing too is that in that context, I was constantly working with people who had depression or anxiety or substance use or whatever. But that all stemmed from this formative experience that they had that was entirely traumatic and it was really clear. You can look at what happens to someone when they do not have a secure attachment as a child.

In relation to understanding trauma in their theoretical and practical approaches to working with women, all of the participants were also cognizant of how historical context, environment, socio-economic factors and relationships play into how women

experience and respond to mental health and substance use as well as how these issues should be approached in practice.

Theory

In discussing theory, many of the participants referred to cognitive behaviour theory grounding their theoretical framework or cited ways of practicing that were grounded in this theory. Jacqueline spoke to the difficulties in navigating theoretical frameworks within organizational institutions that promote certain frameworks over others:

... I am always negotiating frameworks because I work in an agency that uses very much a cognitive behavioural foundation. And I think that is really valuable sometimes... Like I really find that valuable looking at how the meaning people make and beliefs that people have and how it influences their behaviours. And how the social context and the larger messages and the larger beliefs... the larger cultural beliefs - how it impacts. So that interface between their beliefs within the social... within their social or their culture I guess and how that relates to their personal beliefs. And how that relates to their behaviours. That is kind of cognitive behavioural but I think they use more of a social aspect as well.

Some participants provided descriptions of their theory and practice that would fit into specific theoretical frameworks that were not specifically identified. For example, Hannah and Jacqueline provided narratives that were firmly grounded in critical and anti-oppressive theories though they did not explicitly speak to using those frameworks. They spoke about structural inequalities, discrimination, and power. Anti-oppressive practice, which falls under the critical theory umbrella, has been defined by Dominelli (2002b) as:

...a form of social work practice which addresses social divisions and structural inequalities in the work that is done with ‘clients’ (users) or workers... Anti-oppressive practice embodies a person-centered philosophy, an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people’s lives. (p. 6)

Hannah provided this context when she spoke to her work with service users:

I have an analysis around what society looks like. It also involves looking at class and race... anything related to how society values and doesn’t value people based on their identities, or their perceived identities... So I think that inherently involves how I work with people... and drives like... you know... and my analysis around that stuff drives the questions that I ask.

She also spoke to the importance of taking a position in doing therapeutic work when asked about what works for her regarding these approaches to practice, “so this is... it’s the piece around taking a position. So obviously I have a strong position even before I came to sort of doing therapeutic work.”

One of the participants provided an interesting response when asked about theoretical frameworks. She dismissed the usefulness of theoretical frameworks in community settings:

Umm, as I say, like not, probably not super consciously, like I’m sure you would talk to like Clinical Therapists who would be able to tell you the way that they work. I don’t think that, just the nature of the sort of work we do here, like it’s, I don’t think of it as just being clinical so it’s not something I spend a lot of time with. Umm, I definitely work from a... solution-focused and strength-based

approach with people. Just trying to look at, what are the things that are working for them and have worked in the past and... and how they can harness those things. (Melanie)

Reflecting on this response left me with a number of questions. I wondered about how common this idea is and if there are a number of clinicians in our community questioning the relevance of theory in service provision. Given that my belief is that engaging in clinical (or community) work in any setting warrant's a theoretical framework of practice, I wondered how one would rationalize their engagement with clients when they are not grounding the interactions in a theoretical model. Melanie did end up engaging in a discussion around her agencies model of practice that she ascribes to as well:

...we work from a client-centered model... I mean, it's just through experience, like people connect to different things, people connect to different approaches. Umm, it really depends on our relationship with them. The fundamental thing is building relationships. But yea absolutely, some people respond to being more direct and maybe using some humor and other people, it's a very gentle, kind of, leading someone along and just giving them a space to talk and for other people it might be more practical, practically based, like kind of, brief therapy, kind of, solutions. Umm, so yea, and to me, that's my, what overrides all of my approaches, is I would do almost anything with people if it worked, as long as it was what worked for that individual.

Relating these ideas back to the dominant stories around eclecticism in participant responses, the idea of doing whatever works is a common critique of eclectic models of engaging in social work practice (Staub-Bernasconi, 2009). Part of the concern of

engaging in a ‘whatever works’ style of practice, is that it lacks accountability and intentionality.

Theory and Practice

One of the most prevalent factors in participant responses was the tendency to group theoretical frameworks and practice approaches together. Often there did not appear to be a concrete distinction between theoretical frameworks or practice approaches or participants would discuss theory in largely practical ways. Maya spoke to ‘strength-based’ approaches as part of her theoretical framework however identified it as more of a model as opposed to a theory:

Motivational Interviewing, which is, you know, obviously a strength-based approach, but really, it’s not really a theory, it’s just a way of being with people.

And the way of being with people works really well with women with co-occurring disorders.

Part of service providers’ descriptions of theory in practical terms could be due to the overlap between practical approaches, theories, and ideological perspectives (i.e., the term ‘feminism’ can lend itself to feminist theory, feminism as an ideological and political perspective, and feminist therapy). Making clear distinctions between theories, models, practices, frameworks, interventions, perspectives, and paradigms can be very difficult, which is only increased by the notion that many academics and practitioners are not necessarily sharing a common language to describe different aspects of theory and practice (Trevithick, 2008, p. 1221). Most participants were able to make more concrete distinctions between theory and practice when asked clarifying questions (i.e., Would you say that is more of an intervention strategy?). When asked about her theoretical

framework Alyssa speaks honestly to what is likely the case for many service providers working in the field for several years:

Oh my goodness. I haven't been asked this, or given a lot of thought into this in years because you know, as I said, I'm sort of out of the academic world. So you don't often think about, 'what is my theoretical framework.'

She goes on to describe her theoretical approach (humanistic) in a highly practical manner:

...I'd say, if I was just, kind of, pinned down to it, it's probably... it's a very humanistic kind of perspective, really. It's about looking at a patient and where they are in their lives and trying to figure out what is going to be the most helpful for them as opposed to going in with one sort of specific approach and making that for them as opposed to seeing where they are in their lives and trying to make the therapy match... what it is their experiencing. So yea, you know, strength-based right... everybody's got something good that's going for them, really focusing on that and what has worked before and what can continue working for them. And really helping them develop independence and, you know, self-determination. Helping them kind of figure things out for themselves as opposed to doing for.

Perhaps when service providers are out of academic environments and working in the field, is it easier to think about theory in a more practical sense. The language that Alyssa uses in this interview is particularly interesting given the use of the term patient in describing the people she works with as well as the use of the term 'helping.' Both of these will be further unpacked in the discussion.

There were also participants that were making clear and direct distinctions between theory and practice. Hannah spoke about the use of both feminist theory and feminist therapy in descriptions of service provision. She described herself as a feminist therapist with a feminist political analysis and when asked about her theoretical framework she stated:

Feminist. I mean. Theoretical approach, do you want more specific than that? Were you looking for narrative or something like that? Or systems theory? I don't know, I guess, feminist would be the short way of saying it. I have an analysis around what society looks like. It also involves looking at class and race... anything related to how society values and doesn't value people based on their identities, or their perceived identities... So I think that inherently involves how I work with people... and drives like... you know... and my analysis around that stuff drives the questions that I ask.

Feminist theory, practice, and perspectives were overarching themes identified when discussing their practice in working with women. This will be explored further when discussing ideology.

In making connections between theory and practice, almost all of the participants stated that they would not change their theoretical-practice framework in working with clients regardless of who they are working with (i.e., regardless of gender or presenting issues). This was interesting as a few of the participants went back and forth on this belief throughout the interview. Most concluded that they approach all clients in the same manner but will change intervention strategies depending on the client they are working

with. When asked if her theoretical approach changes depending on whom she is working with, Hannah notes:

...how I approach therapy is kind of how I approach everything. So like this is my perspective on... the world that we live in. So its not really something that I put on or like apply in various situations. This is how I integrate information about the world that I am living in.

Jacqueline discusses the consistency of her approach despite her understanding that not everyone she works with are experiencing the same issues:

And although issues might be different with the person depending on their gender and their gender identity.... but I realize because a person identifies as a woman in this culture their issues are different than men in this culture. If that makes sense. Different issues... I think I am the same... I think my approach is still the same. I still work from strengths-based approach. I still say to people that, you know, my job is to become trustworthy.

Maya provides this example from her practice:

Though I always adapt to what's going on in the room. You have to. But my basic way of working, the basic MI way of being, never changes. So I never take an authoritarian stance. I mean, I'll certainly if someone is suicidal or going to kill somebody or something, you know, if there is a crisis, I'll certainly take a stand on what needs to be done. Or if a child is at risk or something like that. But, that particular approach is always the same. Man, woman, or child or family. Then the more specific things that you would do, I would do, are often times different than with women and men.

Some of the participants made distinctions between approach and intervention.

Jacqueline describes this as:

My approach is very different from intervention. I see that as being different.

Yea... definitely. And even my interventions will change depending on the person's situation. I have become very directive, I have become very directive if I feel like someone is in great emotional distress... So my interventions will change depending on the persons situation when they walk in the room and my reading their situation.

While Maya, Hannah, and Jacqueline stated their overall approach would not change regardless of presenting issue or gender, Alyssa stated her approach might change depending on both presenting issue and gender:

Yea definitely. I think that my approach is certainly a little bit more feminist when I am working with women. Especially, I have worked with a lot of abused women. And so, you know, looking at their, I'd say, you know empowering, helping to empower them, to make different choices in their lives and to make healthier decisions so they can develop, sort of, a stronger sense of self. And looking at, kind of, how they have seen themselves and what they have believed about themselves as being women. You know. And how that's sort of, impacted the choices they have made, especially in terms of the relationships that they have chosen.

Although I would suggest the language in that excerpt is relatively incongruent with feminist and empowerment theory, it supports the point about changing approaches. She goes on to state that, she is more likely to approach someone differently based on what

the issues are rather than gender. Melanie agreed her intervention might change depending on what the person is experiencing, however being ‘client-centered’ remains the same. Given that she has not worked with men in her practice she could not speak to different approaches based on gender. Alicia stated that her approach would not change based on whether she was working with a woman who experiences these issues and trauma. However, she also referenced a lack of flexibility in being able to use different approaches in her workplace, as she engaged in crisis work. Due to the flow of the conversation, Alicia was not specifically asked about whether or not her theoretical or overall practice approach changed depending on gender or issue. This should have been explored more fully with her.

Maya described how the specific intervention she engages in might change when working with women versus working with men. She provided this example:

...women are more receptive to mindfulness. So more mindfulness based practice... probably particularly with the women who have... abuse issues and are very, have a whole lot of problems with emotional regulation... some sort of Seeking Safety, grounding techniques, things like that.... women specific treatment, not having mixed groups and things like that...but especially with women because of them being care givers and, you know, we have child care, and we do our groups so that, that, they can be around when women have to be home to pick-up their kids... you know, so we involve, so we look at their life circumstance. Right. So I guess, the difference is, there is differences in, what you actually do... in an one-on-one session or in a group session but also looking at

people's lives... So take into account the realities of women's lives, which are often times way different than men's.

Understanding and unpacking participant stories about their use of theories, practices, perspectives, and models has been both fascinating and complicated. All participants seem to implement eclectic approaches to their practice and at times it was difficult to discern whether these practices were informed, well thought out, and compatible with their practice, or if they were simply based on notions of 'evidence-based' practices commonly used in our community coupled with the use of buzzwords like 'feminist', 'narrative', and 'strengths and empowerment.' Dominant stories are riddled with contradictions and counterstories. Dominant stories about the pathology, symptomology, and treatment based on diagnosis are countered with stories about taking into consideration the 'realities of women's lives' and the historical context impacting day to day experiences. These counterstories will continue to be further unpacked in the following sections as well as the discussion.

Development and Description of Ideology

Participants in this study described a number of ways that their ideas developed about both their theory and practice in working with women who have co-occurring mental health and substance use issues. All of the participants stated that, in part, their ideas have developed through their work history and over years of experience working in the field. Melanie speaks to this by stating:

...primarily I guess just from experience. Like working with people and seeing what it looks like for them... especially working with women...

Jacqueline and Alicia found that the experiences and learning they gained through their social work schooling contributed to their ideas about working with women experiencing co-occurring issues. Conversely, Hannah found that school was not all that helpful in the development of her practice ideas and that many of them were influenced by mentorship opportunities. She describes this by stating:

I didn't go back to school to learn therapy, I really, I really feel like that... I feel like there are sort of augmentations in terms of what I've done in school but the lion's share of learning how to be a therapist and in particular a feminist therapist came from being mentored by women who are really skilled at it.

The other common theme identified, which supported their learning and understanding of co-occurring issues was their experiences in working with women. When asked about where her ideas came from, Alicia answers by stating:

I think the best I can say is that... it's just through my experience as a service provider and what I'm seeing and whether explicitly or in more of a roundabout way, the connections between the two that the clients that I see are making.

Aside from their experiences working with women, a few of the clients spoke to how their own personal experiences have supported the development of their ideas around theory and practice.

Although almost all of the participants spoke to influences of feminism in their practice (See Table 2), there was some disagreement about how it should be used and applied when working with women. Hannah states that she was, "politically motivated," in getting into this work and discusses strong beliefs about therapy being political. Using

a feminist analysis in her practice was imperative regardless of whom she was working with. She unpacks this belief by saying:

...you know, and not that I'm not interested in changing social conditions... but I really do feel there is a strong role for therapy, but why I feel like therapy needs to be political. Cause if I don't actually think that... if I don't think that how she's been socialized is going to affect how she's operating and functioning now, then that's not going to come into how I'm working with her... the politics are {inseparable} from how I work. That's the foundation of how I am coming at looking at peoples issues.

...if you don't have a feminist analysis of why this might be happening to people it does like... you do start talking about people as being manipulative...

Melanie, on the other hand, argued that in a community setting, it is less helpful to have a gendered analysis when working with women. When asked about whether or not this was important, she stated:

I think it does. My experience is that in a setting like this, umm, probably less so. I think, certainly when I've done... if there's general stability, I think there is more space for people to understand that. A lot of the women that we work with, it's umm, getting peoples basic needs met. They're just not in a space where that's, where, they're that interested in that, right. In the same way that... you know, a very different example, but, but, but similarly, like we often talk about the importance of like a healthy diet for people who are dealing with all these stressors. But it's like the last thing on people's minds when you're just trying to get through a day, right.

Melanie seems to be questioning the appropriateness of engaging in these kinds of discussions when working with women who are experiencing poverty and who are multiply marginalized. Clinical judgment is an important factor in understanding the appropriate times to engage in these conversations with service users. Feminist ideological perspectives in working with women will be further unpacked in the discussion section.

The other interesting ideological perspective that was discussed by a few of participants (Jacqueline and Hannah) was the use of spirituality in their practice. Spirituality in social work is still a developing concept, however some literature is identifying it as, “an important emerging component of practice,” (Coholic, 2002, p. 2). The focus of their spirituality was centered on the presence of Buddhism in their lives and how it affects their practice. Jacqueline describes spirituality in her practice as:

I also take a spiritual lens through the work that I do. I am studying more Buddhism and there's a lot of... Buddhism offers a way of understanding suffering and the human condition, which I find resonates with the work that I do and with my own self. So there is a spiritual knowledge I guess or spiritual reference or... spiritual body of beliefs... yea I guess body of beliefs that I am looking at more and more. That kind of informs how I do work with people and how I look at... substance use. As a way of... creating suffering and managing suffering at the same time.

Hannah describes its influence on her practical interventions by stating, “I'm really quite a strong mindfulness practitioner, I'm a Buddhist, so all of that stuff really influences how I work.”

Barriers to Service Provision

There were a number of barriers to service provision outlined by the participants in this study. Barriers are broken down into three subthemes: Systemic and Institutional Ideology, Organizational Structure, and Gender-Specific Barriers. All of the participants provided rich descriptions of barriers they have faced in working with this population in their practice. These descriptions are outlined below.

Systemic and Institutional Ideology

Each participant in the study provided at least some critique of the difficulties in working within an institution or system that is highly focused on the medicalization of mental health and substance use. Participants spoke to how women accessing these systems experience rampant sexism and are intersectionally marginalized and discriminated against based on gender, race, socio-economic status, age, and sexual orientation. These systems privilege ‘evidence-based’, neoliberal methods of treatment (e.g., simplistic, cost-effective, manual-based treatments), while rejecting others that may not ‘fit’ as well into brief treatment models of practice. Hannah explained these concepts best by acknowledging:

...we work largely in a medical, pathologizing model, that is not trauma informed. That's system language - trauma informed. But it is not trauma informed. But that is a real problem because the diagnostic criteria for PTSD and borderline personality disorder are virtually the same... and... most women who come through mental health get a BPD diagnosis not a trauma diagnosis. Or they get both... they get trauma with Cluster B traits.

In unpacking dominant institutional ideology, the following provides a further description of how participants work within a system that has a tendency to pathologize, label, and regulate women's experiences, especially around trauma and diagnoses, such as, borderline personality disorder. These narratives also describe their analysis of systemic oppression and sexism as well as alternative stories of resistance to dominant discourse:

I mean you know women have oppressive and damaging experiences based on their gender. Right just like other groups have um... experiences based on their gender. It ends up... its interesting cause... how the system works with those things is to pathologize them into a diagnosis. Like for instance, borderline personality disorder is just like rampantly... you know, this is sort of like a bee in my bonnet right now. I mean, you know, in addictions it was the same. (Hannah) Because I don't think there is an analysis of... you know... personality is a description of something that is intrinsic and who you are. Trauma is something that happened to you that you are responding to. They are just very different. It is the same set of symptoms. Right... it is exactly the same symptoms... as opposed to not wanting to interact with them because you figure that they are beyond help. That's the other thing about BPD, lots of people feel like you can't actually work with them. (Hannah)

... I never try to use the labels that health professionals give women. Or anybody, again it is anybody. But I am really sensitive like... one like borderline personality. Talk about stigma. All you have to do is use that word to describe somebody, it's usually a women, because the majority are women. I guess I am

really sensitive to the stigma. I am really sensitive to the history of that label and what that can mean for people and the damaging effects that can have.

(Jacqueline)

I sort of look at it historically too, like, when you hear about those old diagnosis of the hysterical women. To me, like we have now labeled that borderline right. So like, this is something that has always gone on. And I think a lot of what it is, is that, that kind of work is hard and it's, it is, often like, it feels very personality driven and so... umm, I think it is just something that as a society we've kinda said, well if women have this experience, which happens more with women because trauma is more common with women especially like sexual trauma and things, you know, and the presentation is difficult to work with and once the label is given, it lets people off the hook to a certain degree. Oh, someone with borderline oh well, there not, you can't really fix that. Problem patient, like the end. (Melanie)

Some of these narratives are exploring the difficulties service providers may face in working with women experiencing these issues as well as how the provision of that label comes with a significant amount of stigma. The BDP label may serve to allow service providers justification in their inability to provide adequate supports. This speaks to the need for more clinician training which will be discussed in further detail. Melanie also acknowledged that the, "system is unkind to women." She describes further her experiences in working with women:

A lot of people that we work with... have to operate within some pretty dehumanizing systems and working with income assistance or family and

children's services or the hospitals system and that kind of thing. And those experiences aren't always great for people and it certainly doesn't help in terms of how people feel about themselves. (Melanie)

There was an overall agreement between participants that institutional ideology and dominant discourse act as a barrier for women experiencing co-occurring issues.

Given that dominant language practices or discourse help shape and give meaning to our lived experiences (Healy, 2005), the language people use working within healthcare systems help create our ideas about the clients we work with. Many of the participants critiqued the language used to describe women who experience mental health and substance use issues:

Mental health issues yea... and that's always something I struggle with too as a social worker as well... kind of the is the label around mental illness versus mental health issues... (Alicia)

And so that becomes a personal failure as opposed to like... stuff that doesn't make it onto the referral. I'm like 'oh your in an abusive relationship, nobody mentioned that.' It's just like... you get borderline personality disorder, you know, and I'm just like, 'how many years were you raped as a child for?' You know, and that's not... that information is just omitted right... There just still like let's look at the symptomatology right now... symptomatology, that's really picking up on the lingo. (Hannah)

And the language that I've heard from folks in the system speaking about this... is really... and I'm not at all intending to demonize those folks. I really do feel like its... feminism is kind of thin on the ground right now. It's pretty passé, its

not really... even in terms of on the left, it's just sort of like everything's moved past that and we're beyond gender! (Hannah)

Some of the participants, even those with a systemic analysis of oppression, at times engaged in pathologizing language. This could be due to certain terms or descriptions being commonly used in their work environments as well as the fact that dominant ideas about mental health problems are based on DSM diagnoses. When asked about the kinds of mental health issues they see in their practice, participants responded:

...we used to find, well we still do, a lot of women with, umm, what we used to call Axis II diagnosis of personality disorders. Umm... So a lot of people that can be diagnosed with borderline personality disorder and some others. (Maya)

We work with a number of women who have borderline, umm, diagnoses - whether or not that is something that is real for them. (Melanie)

...women who have really severe mental illness. So I work with women who have bipolar disorder and umm, who have very complex and severe personality disorders that are impairing their ability to function. And ah, and then we see women who have just sort of general anxiety disorders and depression. (Alyssa)

There were also a number of counterstories of resistance to pathological language and to a system that privileges the medical model and 'evidence-based' practices. In discussing how she navigates working within these systems, Hannah states:

I mean fuck... when I was at... we would get women coming in with all kinds of diagnoses - I've got bipolar, I've got... you know everyone had a BPD diagnosis... borderline... and we just never took that seriously. We were just like

oh yea... it wasn't even... which is interesting because where I am working at now, they are like 'oh God BPD' you know they don't even screen for trauma. She goes on to discuss how she works with her colleagues in a way that I would describe as 'elegant challenging' (Allan, 2003, p. 71). This is defined as, "questioning the attitudes and actions of others in tactful and constructive ways that allow people to save face and avoid unnecessary hostilities and tensions." In her practice this looks like:

So I guess... how I approach things now... same approach I am trying to use with clients - I also use with colleagues, which is just coming from a place of compassion for the ways that they are doing their thing. And I don't always agree with them but I don't always agree with lots of people so... it's kind of like a... what I notice is that they respond to that. Things will happen in staff meetings where people will get their backs up. I just try to be gentle in all of those situations. And I think people really respond to that. Especially when... if they're talking about... if someone is talking about a client in a really judgmental or punitive way...

I am very strategic about how I... it's not that it doesn't influence how I am at work and how I have conversations about clients and things. But it is very strategic because I have an awareness around what will get peoples backs up and make them feel defensive and what might be sort of a more back door way of helping them see things in a new way that interests them. And people are really interested in... they really like having someone in the Clinic that does a lot of trauma work... everybody refers those folks to me. There... you know... people feel really overwhelmed with this stuff... which you know... you can have a real

sense of compassion for when their talking about clients and they are like, ‘I have no idea what to do with this person…’

Perhaps this is a way for Hannah to be an agent of change within her organization. It seems that she has found that responding in ways that are non-judgmental and strategic may produce better results in creating change and shifting attitudes. The last quote refers to a lack of client training, an issue that will be further discussed under organizational barriers.

Organizational

In discussing organizational barriers to service provision, many of the participants were critical of brief treatment or intervention models. Brief treatment generally occurs over a limited number of strategic sessions. It is very much a neoliberal idea that has been introduced in order to provide cost-effective treatment that fits into the ‘evidence-based’ ideology. In discussing the use of treatment manuals in clinical practice, Alicia stated:

I don’t know… I think it comes back to the medical model and the idea that in order to provide good quality care it has to be scientific and therefore it has to be evidence-based and therefore it has to be laid out in a manual.

She goes on to argue that brief treatment has the ability to affect quality of treatment:

Brief treatment. Yea, so you are already putting a timeline on when that person is supposed to be better. So it’s a real indicator of where we’re at in terms of our resources. I know it leaves the individual front line clinicians really limited in terms of the quality of the work they are able to offer. So those are real restrictions, those are real barriers by this system.

Hannah discusses brief treatment in terms of its ability to provide support to those who may not fit into the models being privileged at the Nova Scotia Health Authority:

So basically the idea is that regardless of who is sitting in front of you and what their bringing, you should be able to do six sessions of CBT which involves actual sheets that you fill out with them. And like what their offering is something that is outside of the sheet, you need to go like, “well that’s nice but we really need to get back to focusing on you getting better,” you know... So anyway that’s how they teach therapy in Capital Health... And um... for the most part I have found that curious and not very helpful.

Jacqueline provides a similar analysis in terms of brief treatment approaches being unable to provide meaningful therapeutic treatment:

Organizational structuring definitely... were under this new system where you’re supposed to be working with people for six sessions... I mean that’s... if you can tell me how I can work with somebody meaningfully... with a women with co-occurring mental health issues and substance use in six sessions? Like, it is totally unrealistic... that’s a huge barrier for me.

Jacqueline and Maya also provide counterstories of being able to navigate through the brief treatment models in their work environments:

I am trying to find ways to get around that. But that’s really hard. That’s damn near impossible. The only thing is... I think for me it’s just, I have really been able to stretch that out and work with my supervisor to make cases for working with women longer than that. Cause that’s just not realistic at all... But what I always say to folks is that we have six sessions and that... as were getting close to

six sessions, you and I need to sit down and figure out how many more sessions you need, if you do need more, and then I will advocate for more time. And that's what I have been doing and I tend to successfully advocate... (Jacqueline)

We did bring out umm, about a year ago, a brief intervention model here. Because particularly with women it is easy to hold onto them for five years right. There is so much going on, once you have that relationship... so that... a lot of the more complex work with women, doesn't fit into six sessions. And... so, our organization has been very flexible around some of those complex situations that we allow people to go past six sessions. (Maya)

Though both narratives are describing an alternative story and an ability to navigate through the brief intervention model, Jacqueline describes it as, "whole song and dance," where Maya describes the organization being "very flexible." This discrepancy could be due to organizational roles, as Maya was in leadership/management position.

Hannah also presented a counterstory to the prescriptive nature of the work happening within the Nova Scotia Health Authority. Although there are dominant ideas about practice within our formal systems (i.e., medical model, evidence-based, brief treatment, etc.), Hannah has been able to practice social work in authentic way with a feminist analysis and feminist based framework. She acknowledged that her employers have been largely supportive of practice and have allowed her to work with clients in a way that makes sense to her:

...it's so funny... because Capital Health has a representation for being really regimented and 'we're going to do things this way' but you know... since I have been working there they really kind of let me do whatever I want... I would just

come up with ideas for groups and they would be like ‘sure do that.’ I would like ‘okay.’ Which was slightly modified group that I had designed and run at [a women’s program]… I am going to be running a trauma and mindfulness group this summer for women. It’s the same themes… I was surprised when they hired me at Addictions. Then they were actually quite into what I was doing which was nice… once I figured out how to navigate that situation in a way that worked for everybody (laughing). And the same with Mental Health.

Stories of resistance to dominant discourse are important because they help us imagine that there can be change despite working within a medical based model of practice.

One of the other primary themes that arose out of organizational barriers to service provision was the ongoing, siloed approach by mental health and addictions despite the amalgamation. Mental Health and Addiction Services in our province have historically operated separately from each other, however as previously stated, the services have amalgamated into one program over the last few years. Many participants felt that from what they have seen, the changes have not yet been translated into frontline practice (Hannah, Alicia, Melanie, Alyssa). Hannah spoke to this by stating, “our experience so far is that it has been largely administrative.” Participants spoke to their thoughts and feelings about the amalgamation:

And so… mental health and addiction are siloed right now. Theoretically we’re amalgamating right, although when I was still at addictions, I was like so… what’s going on there exactly? Well that’s really more of an administrative merge right now. There’s like one guy that’s in charge of everything but… anyway… I really, you know, they’re treated as very separate entities. (Hannah)

And it's interesting because how the system works is that we're going to send you to the eating disorders clinic for that piece, and were going to send you here for that and like... if your cutting, then we think that you have borderline personality disorder so nobody wants to work with you... (Hannah)

... I mean, I don't have a super a lot of faith in like our Addictions system here but umm, I think that there is tendency to isolate the two pieces and not look at them together. So that's definitely a barrier. For us, I mean the people that I work with, don't access a lot of services... So... and yea, it would be great if there was more recognition that the two really do, or really can co-exist and when they do, then that is work that really needs to be done together. It is frustrating for people when, when were making referrals or when you're working with someone, to say to them, okay like your working with them on this, or so were doing some work around your addictions issues but you really need to talk to your doctor more about your mental health stuff or your mental health support. Umm... cause we don't always work the same way, and so those things don't always mesh really well. So if there were more services that would look at them both together that would definitely be umm, helpful for folks. (Melanie)

It is getting a little better. There is still huge systemic barriers. The barriers are that we don't use the same databases. We actually have a better database than Mental Health. We have, like a, a database that holds our records. But we also have to use a paper file because that database is for all, the whole province. The ASSIST database for the whole Province doesn't have the mechanism to do umm, ah, notes, yet. So we have to have a paper file. Everything that Mental Health uses

is just scanned copies. So it is a paper file that is scanned into an electronic file. So they can't like, pull out, we can pull out some really good data... And there is still some old fashioned beliefs that, ah, in mental health, that you need to stop drinking and then come back... Go to Addictions, stop drinking, and then come back and we we'll take a look at that mental health problem... luckily we have two psychiatrists, umm, a PhD psychologist, and we have a mental health nurse who comes in here and does a lot of those real mental health, medication type, assessments for us. (Maya)

Jacqueline had a somewhat different view of the changes between the two systems. She describes seeing numerous changes however she does not necessarily see them all as positive. She saw Addictions Services becoming more like Mental Health. When asked about whether she has seen changes, she stated:

Tons, yea. So what I see, is that we are becoming mental health, basically. Were starting to use the same forms as mental health. Were starting to... yea... there has been changes... so yes there has been on some levels and on some levels there haven't been. I have been seeing more conversations between mental health practitioners and myself and the addictions side. We are basically going to be taking... we are using a lot of their documentation, which can be helpful and can be problematic. It can be very problematic some of their... some of their documents... languaging... definitely more of the medical model language, which is problematic... It will be interesting because I am going to work in a mental health clinic, like I am going to be embedded in a mental health clinic and I have been told there is a lot more collaboration that happens. A lot more co-

consultation between people... And I am really actually really looking forward to that. Yeah... there is going to be lots of changes... Yeah... they are coming down... things travel and things are really slow to change but there will be. There will be changes for sure...

...but a big change that has happened in front line, that I just realized, was... sometimes I forget the obvious... is, we are now... our Clinical Lead is a psychiatrist right... and so we have an Administrative Director and a Clinical Director. And he is a psychiatrist. Lovely guy, nice guy... but he definitely uses the word... I noticed in our meetings now, the word patient comes out more. I have never used patient to describe the people that I work with. I call them human beings... men, women, people... sometimes client, yes I'll use the word client, if it fits... but now he... I hear the word patient a lot. That's interesting right... addictions has never used that word patient. He calls it patients. He calls it disorders... substance use disorders... out of the DSM model. So that... and we have hired a psychologist now, lovely woman... very nice. But they have a different lens. They truly have that... that inner... they don't have that... they don't have that social perspective I think... when they start to look at what issues there are and what interventions should be helpful. They use very much that inner, that psychological perspective, you know, and medical. Definitely. I see that really changing. So, and I am a little disturbed by that. And... that's one example where I see changes... (Jacqueline)

Most participants were hopeful that Nova Scotia would continue to provide more cohesive services moving forward. When asked if she thought Nova Scotia will get there,

Maya responded, “Oh God... They have to. And they know they need to. I guess it’s just, sometimes it’s hard.”

Melanie and Maya spoke to accessibility (i.e., getting there and feeling comfortable) in terms of people accessing services. Melanie spoke to the issues of accessibility for the population she is working with:

...and so, sometimes you find that the work that we do with people, there is lots of great referrals I could make, to you know, Addictions Services or Mental Health, but it can take a long time for those things to happen and those systems feel like systems... you can have good experiences with them, with therapists or counsellors... but I know Addictions Services for example, it feels pretty inaccessible for lots of folks, just by the fact that you go, it’s an office, it’s downtown, it’s not here, and it feels like a different kind of world for people and so they don’t always follow through. So I think that one of the barriers is that we have some really good services in the city. But they’re not, it’s like anything, they are really good for a certain population of people. Maybe not people living in poverty.

Maya spoke to the implementation of outreach services to try to address this issue:

... issues of finding each other. Lets call it that. We’re often stuck in an office, there is no parking. Bus access isn’t good. I think accessibility. So our women’s program is going out more into community, like, Family SOS... They are at, you know, Adsum House. Going for like, I think, a lot of places that provide services to women [and] don’t have a connection to people that work in the field.

Other organizational barriers that were commonly noted had to do with clinician training across both mental health and substance use. All participants felt that, in general, clinicians were not effectively able or knowledgeable enough to work with both areas concurrently. Maya spoke to the reality that social work students are not always adequately prepared upon graduating from school to work with these issues. Other participants felt that this contributes to why there has been an in-flux of evidence-based models of practice, given that clinicians are not necessarily properly trained to be ‘good therapists’ (Alicia and Hannah). Maya spoke to one of the changes they have made to try to address the issue of training:

Now one of the really good things is that, umm, Mental Health and Addictions, really is working on competencies for all our workers. Because there is a lot of people in Mental Health that still don’t want to touch anybody with addictions. Not so much people in addictions that won’t touch people with mental health. Because we’re used to it. We’re used - everybody, mostly, I would say 85% of people who come in here, have some kind of co-occurring situation. That doesn’t happen in mental health... We’re working as an organization... everybody has to be trained on concurrent disorders, umm, up to a basic level in both organizations, which is like almost 1000 people. And we have an online training tool that’s being rolled out sometime soon. And then you have to have so many people in your office that have an intermediate level and some people have an advanced level of training in co-occurring and concurrent disorders.

The idea of meeting certain competencies for training is similar to ideas around evidence-based practices. It would be interesting to explore this further in terms of what it actually involves in order to reach different levels of competency.

Some of the participants spoke to organizational barriers such as, waitlists, time constraints, and increasing workloads (Alicia, Jacqueline, Alyssa and Maya). Jacqueline stated that there is pressure on clinicians to see more and more people, which can then make you feel like you are, “hurrying people along.” She stated that only having 50-minute sessions and then ten minutes for documentation can prove problematic, especially when some clients require more time. Alyssa identified a number of issues related to identifying organizational barriers such as: high caseloads, limits in service provision (e.g., number of sessions, not enough time to provide groups), limited funding, and issues related to what is seen as valuable for service provision and what is cost-effective (i.e., social work versus psychology versus psychiatry).

Limited funding and limits on service provision are related to a lack of resources and treatment options available to women with co-occurring issues. Alicia spoke to this by stating:

So its a real indicator of where were at in terms of our resources. I know it leaves the individual front line clinicians really limited in terms of the quality of the work they are able to offer. So those are real restrictions, those are real barriers by this system.

In order to gain access to mental health services, someone must be experiencing fairly significant issues. Often people are being turned away from services due to not being acute enough:

...lots of people aren't ready for group and lots of people find it really triggering and lots of people just aren't really interested in it and I don't think should be forced into it. But certainly the way our mental health system is looking right now that the primary modality is group. For instance, at the Clinic that I am working at, you don't really get on to the wait list unless you're quite complex. People who are coming with - what they are calling - run of the mill depression, anxiety, whatever... all get referred to group. (Hannah)

Hannah, Jacqueline, and Alicia spoke to the challenges of working on interdisciplinary teams given that service providers from different disciplines are coming from different philosophical understandings of the issues their clients are experiencing. There was also an acknowledgement of a hierarchy existing within service providers with psychiatry being at the top.

The final organizational barrier that stood out was the need for both Mental Health and Addictions Services to screen for trauma. This was noted to some extent by most of the participants in the study. As previously demonstrated in service provider narratives, trauma histories may not be included when Clinicians are receiving referrals. Hannah stated that:

...you know they don't even screen for trauma... So... I mean I guess some of them do - maybe that's not entirely fair. But I have certainly picked up enough people off the wait list now where I am just kind of like... they have got all of these mental health diagnoses... and then when I start talking to them, it's like so you've had like 15 different experiences of trauma and they have been really complex or whatever. But this is really about your depression right now....

[sarcastic]. So it is a perspective and it's obviously not the perspective of everybody but I don't actually think that people display symptoms without a reason.

Gender Specific Barriers

Participants in this study described a number of issues related to women's experiences that impact their ability to access services. All participants spoke to concepts related to patriarchy, sexism, socialization, intuitional discrimination, and stigmatization. Women, especially mother's, often experience significant stigmatization related to mental health, trauma and substance use issues. Maya states there is, "a lot of stigma associated with a woman who has a drug and alcohol problem. Especially one that's a mother or who has a family..." Many of the participants acknowledge there is a lack of resources for women in trying to access treatment:

They don't have access to resources because they're living in poverty or not having an address or all kinds of things. (Melanie)

I think women have an uphill battle to get resources to take care of themselves. Their physical health and mental health. Uphill battle definitely. (Jacqueline)

Participants argued that women are often multiply marginalized and involved with a number of systems that are making their lives more complicated (i.e., Income Assistance and Child Protection). Many of the participants acknowledged both Income Assistance (IA) and Child Protection (CP) provide significant barriers in accessing treatment.

Participants spoke to the barriers that being a parent, especially a lone-parent, can present in accessing services. Women experience fear related to having their children removed or having CP involvement. Alyssa acknowledged that women with children may feel the

need to hide the issues they are experiencing related to substance use for fear of repercussions. This is especially true for pregnant women. Jacqueline explores barriers to women who are mothers by stating:

...women who have small children... or children under the age of 12... that whole children's aid can be incredibly detrimental to me working with women. I continue to have that challenge, negotiating that challenge of women who have come into see me for support and have children's aid involved in their lives. That can be very... that can be a real barrier for sure.

Often women experiencing these issues are also dealing with poverty related issues such as transportation, childcare, housing, and food security which make accessing services much more difficult. Hannah speaks to this by stating:

At Addictions I had a lot of contact with, or not a lot - I tried to avoid it, but when it was helpful I would have contact with Children's Aid. And you know, Department of Community Services, I will have contact with them in terms of like: this person needs a bus pass to come and see me; this person needs this or that. That's just sort of... every place I have worked I have done a lot of that. The culture, you know, neoliberalism or whatever you want to call it. People don't have any money and you know, need help getting that if we can get them an extra, however what it is, if they are on disability versus regular assistance...

Many of the participants also spoke to how women struggling with these issues tend to experience more shame and self-blame and less self-worth (Hannah, Jacqueline, Alyssa, Maya, and Melanie). Hannah speaks to this by stating:

...even with depression and anxiety it doesn't necessarily have to be trauma or substance use, it's all the shame and self-blame around that are... I think have something to do with gender.

Melanie speaks issues of self-worth:

...the other that I have noticed that seems to be right across the board is ah... because of the experiences they've had and the situations they've been with and the support they've gotten or lack of support there seems to be... umm, a real prevalence of a lack of self-worth. Like people not believing that they're worth things or... that they're deserving of a stable life or a healthy life. And it's hard making choices when you're in that mindset. I think a lot of that contributes to that as well.

Another barrier for women accessing treatment was noted to revolve around Inpatient Withdrawal Management Services. Maya and Jacqueline had some thoughts around the structural issues related to inpatient treatment for substance use. One of the primary issues identified had to do with being able to access a bed. Maya stated:

The biggest barrier is getting people into a bed at detox... That's the biggest barrier. That's what, everybody you talk to, all the women services in the community, they'll say, just tell me how to get a bed... You know, it's like, it's really difficult to get in.

Other issues were primarily related to women feeling safe accessing inpatient services.

... Our withdrawal management program, mostly male... we now have, just recently... we used to have a separate section for women in our withdrawal... inpatient withdrawal management unit right... they have taken that away... so

now it is men and women throughout the unit... well (ha ha) that is not going to work for the majority of women. That is just not safe. That is a structural problem for sure. Very much a structural problem. (Jacqueline)

It is very difficult, I wouldn't want to go in detox if there was men there. Not a chance, wandering around in their pajamas, you know, like, all agitated cause they can't drink. I mean we have, we have, separate beds or whatever, but the common areas and everything are the same. So I mean, I really think it would be, you know we probably should have, I think we should have women's only everything. You know, when it comes to this kind of treatment... I really like, if I think that was me and I ever had a mental health concern and an addictions concern or something... I would be freaked out by some man looking at me or, you know. And I haven't had any abuse issues. Right. And that's what I hear a lot of women saying... oh like I just couldn't stay there, right. This guy was hitting on me... (Maya)

Jacqueline felt this is a huge barrier to women remaining in treatment:

The numbers are just a lot less for women than for men. And I think... and I have had women leave who say, 'I'm not staying there. I don't feel supported there. I don't feel safe. I feel like I have condescended to... I feel like I was judged,' and they leave... Which is what we know about women... women won't stay in services if they don't feel that support. That relationship is so important. So there is a whole lot of other barriers...

Jacqueline also spoke to the systemic discrimination women face, stating that she felt their behaviours are scrutinized more than the behaviours of men:

...a lot of systemic or a lot of discrimination that happens in my experience on a day to day level... day to day basis from walking into the doors of Capital Health... from walking into the doors of our Withdrawal Management Unit. It is not safe for a lot of women. If they leave because it is not safe... it is misunderstood. It is stigmatized, it is judged... by other women... women who are health professionals are judging other women who are not... it is very sad. It's very sad. It's very hard for women I feel in a lot ways...and men's behaviours are scrutinized much differently than women's behaviour [at Inpatient Units]. There is an acceptance of... men will engage in aggressive behaviours and it is totally like... ugh... you know eyes are rolled. People roll their eyes and they say 'oh you know he is such a pain' but they get to stay right. There is lots of allowances made, there is lots of second chances. But when women engage in behaviours that could be aggressive there is very little acceptance. There is very little patience for it. And... women are criticized by staff by the way they dress, by the way they behave and by the way they act. And it just feels like men are given a lot more of a free pass and a lot more leniency.

Participants in this study presented a number of gender specific barriers for women in accessing treatment for mental health and substance use issues. It is widely supported across current literature that women tend to face more barriers in accessing treatment than men (Brown, 2009; Brown & Stewart, 2008; Gose & Jennings, 2007; Greenfield et al., 2010). Participants also made a number of recommendations for change.

Recommendations for Change

Study participants made a number of suggestions for changes or improvements to service provision in the treatment of mental health and substance use issues in women. The primary recommendation made across participant accounts involved having a less siloed approach to the treatment and service provision of mental health and substance use in women. As previously stated, many of the clinicians acknowledged that the amalgamation of Mental Health and Addictions Services into one program has not yet (at the time of the interview) been translated into frontline practice in many ways. According to participants in this study, the amalgamation has been primarily administrative in nature and they argue that there is a need for increased communication and collaboration between services in order to better meet the needs of the women seeking supports. Alicia rationalizes her recommendation in terms of the detriments to not working collaboratively:

And not... not duplicating service or sending mixed messages around what might be helpful. Umm... and I think maybe that happens a lot... a lot more than I know about in terms of... maybe ongoing and regular contacts between the two clinicians and making sure they're kind of on the same page. But I've seen it not working that collaboratively as well... and the clients seeming to be spinning and not really knowing what the plan is. And... and not really satisfied with the support they were getting.

She also suggests the importance of clinician training across co-occurring issues. Clinicians should have an understanding of both mental health and substance use as well as how to work with them simultaneously. She explains that treatment is most effective when, "...the best practice is known to be kind of the one shot deal. The one intervention

with somebody who is trained and equipped to address both.” Alyssa discusses how additional training will be supportive in decreasing clinician’s discomfort in working with certain issues. Conversely, Hannah discusses additional training in terms of the need for a more feminist and trauma informed approaches to therapeutic work. Melanie also provided this feedback stating:

I think just more work around understanding the experience of trauma... From my experience anyway, with those, when they are coexisting, it's often related to trauma... and just if there is more understanding, and knowledge, respect and value around women's experience of trauma then all of that work is gonna be better. Because people will recognize the part that it plays and umm, that's I think important to any of that being successful.

A few of the participants spoke to the importance of feminist and/or gender specific treatment available for women. Hannah believes that having a feminist political analysis could be supportive to service provision moving forward, “ideally I would like to see [mental health] having some kind of a political analysis informing how people are working.” Jacqueline discussed what this might look like in practice by suggesting an expansion of the Women’s Matrix Program at Addictions Services into a Mental Health Wellness Program for women. Maya also talked about more women-centered options stating, “yea well more women’s programming would be great. In mental health, I don’t think they have any specific women’s program.” There was also the recommendation for women’s only Withdrawal Management Services, “I mean I think we should have a women’s only detox unit.” (Maya)

Both Jacqueline and Hannah spoke to the need for depathologizing and non-judgmental approaches to services provision in Mental Health and Addictions. Jacqueline discusses the issues around language related to medical model dominant discourses:

I would like to see an overall reduction in the medical model and the power of the medical model. Were starting to see that now. I always use substance use, I hear... now I hear addiction a lot. Addiction, addiction... people with addictions... I don't prescribe to that addiction... I say substance use, gambling, drug use behaviour. Were talking about disorders more in the language. Disorders. So another thing that has happened in addictions, and it's funny because we have always used the word addictions...

Many of the participants spoke to the service barriers associated with the complex and unique issues women face in accessing treatment. Jacqueline speaks to the need for more resources around basic needs for women struggling with these issues:

And continue to work at advocating for more resources for women who are harmfully involved with substances. Because there is not enough. There is not enough residential programs, not enough resources. There is so much more that can be done... Like concrete resources, like childcare. So women can actually come to programs. If they want to come to day treatment and they want to come all day, they are able to do that. Transportation. You know, food being given out. Cause so many women live in poverty. Aren't able to feed themselves. And also more advocacy as an organization... more advocacy as an organization to work with community services. Because of the restrictions that are happening now, the

financial restrictions that are happening to people who are receiving income assistance.

A few of the participants have noticed that some of these pieces are already happening, which elicits hope for the future. Melanie and Maya spoke to new women's outreach programming at Addictions Services that provides more low barrier services to marginalized women. Maya acknowledged that, "our women's program is going out more into community... a lot of places that provide services to women." Partnering with community agencies and providing low barrier approaches is a small step in targeting marginalized populations of service users who would otherwise be excluded due to service barriers.

CHAPTER FIVE: DATA ANALYSIS

The following chapter will provide an in depth analysis of the findings as well as connecting the themes back to current literature. The analysis will further explore the understanding between co-occurring mental health and substance use in women as well as the connection to trauma and eating issues. I will look at connections between theory and practice and recent literature on the use of eclectic practice model. I will further explore the barriers identified by participants, which will include a discussion around dominant discourse and ideology ingrained in the systems that work with women who experience co-occurring issues. I will explore recommendations made by participants and how they relate to findings in other studies and I will also overview potential implications for social work practice.

Unpacking the Relationship Between Co-Occurring Issues

The findings are consistent with current literature outlining that there are many potential models of how substance use and mental health may influence or interact with each other (Skinner, 2005). There was no clear consensus of exactly what the connection was, rather an overall agreement with participants that a relationship does exist which is consistent with current ideas about co-occurring mental health and substance issues (Health Canada, 2002). Participant answers seemed, for the most part, to convey an understanding of the relationship between co-occurring issues in terms of a secondary model (i.e., the development of substance use or mental health increases the likelihood of developing the other issue) or a bidirectional model (i.e., the presence of one issue can increase susceptibility to problems in the other area). The bidirectional model recognizes that there are a number of factors contributing to the development of co-occurring issues

(i.e., mental health, substance use, trauma, eating issues, etc.). Negative outcomes experienced by the first issue can exacerbate the onset of the second issue (Skinner, 2005). Exploring how service providers understand the relationship between co-occurring issues is important because how it is understood will generally affect one's approach to intervention and treatment and the expectations around outcomes. Highlighting this issue, Skinner (2005) states:

Determining the functional relationship between substance use behaviour and mental health problems often shapes the counsellor's expectation (e.g., of what will happen if the client stops substance use). If the client is experiencing problems directly linked to substance use, stopping or reducing use is likely to lead to improvement in mental health symptoms. On the other hand, if the client is using substances to get relief from distressing mental states or from difficult situations, getting him or her to stop use could worsen the client's subjective experience of distress. (p. 6)

How co-occurring issues are understood can often largely depend on the individual the experiencing co-occurring issues. As an example, if the relationship between mental health, substance, use and trauma is understood as trauma being the third variable leading to other issues, then a trauma-specific approach may be used. Alternatively, if the belief is that the issues are mutually maintaining then an integrated treatment approach may be used such as Seeking Safety (see Najavits, 2007).

Participants in this study did not provide a narrative about how they may work with someone depending on how they understood the relationship between co-occurring issues. Although participants stated that their intervention could change depending on the

presenting issues, they did not specify which interventions they would use (e.g., participants did not state that for alcohol and depression they would likely use CBT). Participants were also not explicitly asked these questions, which will be further discussed in the studies limitations.

One of the most interesting findings was participant ideas about whether or not substance use (and mental health) had more of a biological or social origin. Many of the participants told conflicting stories about their understanding of etiology and how the two relate and interact. Although all participants seemed to lean more towards a biological origin with regards to severe and persistent mental health concerns, most of the participants agreed that there are environmental and historical contexts that affect both mental health (especially for issues such as anxiety, depression, and what is categorized as personality issues) and substance use. Sanders (2007) outlines that notions around biological etiology became especially predominant in the 1980s when the pharmaceutical industry became focused on mental health treatment. Mental health problems became essentialised through medical model discourse as genetics, medical illness, and biochemical imbalances (p. 61). He cautions the understanding of mental health in this manner by critiquing the power of the DSM in explaining mental health issues:

a plethora of so-called disorders have been invented, named, and localized within the behaviors of individuals, with little attention being given to the sociocultural and socioeconomic contexts within which human beings experience difficulties and struggle. (p. 61)

Medicalizing women's issues has a long history in western culture (Foucault, 1978; Sanders, 2007; Strong 2012; Ussher, 2010). Foucault (1978) has argued that:

A hysterization of women's bodies: a threefold process whereby the feminine body was analyzed-qualified and disqualified as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practices, by reason of a pathology intrinsic to it... (p. 104)

Despite this, many of the participants provided an understanding of mental health that included social, historical, and environmental contexts (i.e., trauma history, relationships, support, socio-economic status, housing, etc.). This is consistent with existing feminist literature understanding mental health issues in women from (at least in part) a social constructionist perspective (Brown, 2007a; Lafrance, 2007; McKenzie-Mohr & Lafrance, 2010; Ussher, 2010), which takes into account, "political, economic and discursive aspects of women's experience" (Ussher, 2010, p. 15).

There were more conflicting stories told around the etiology of substance use issues. Half of the participants brought up the potential involvement of a genetic predisposition or biochemistry related to substance use. However, substance use was mostly discussed in terms of a secondary response, coping mechanism, or behaviour. Sanders (2007) states that dominant ideas about understanding substance use in this way are relatively new:

Only recently has there been a veering away from the predominant way of conceptualizing the etiology and treatment of substance misuse deriving from the discourse of a disease model metaphor. (p. 60)

Sanders (2007) goes on to discuss how viewing harmful involvement with substance use through a 'disease' discourse is a very old idea and that recent research into the biochemistry of 'addiction' is, "latest, albeit most sophisticated, variant of the history of

the disease metaphor” (p. 60). Advances in neuroimaging and neuroscience have allowed scientists and policy makers to increasingly, with supporting evidence, reframe substance use or ‘addiction’ as, “a chronic, relapsing disease of the brain” (Leshner, 1997, p. 46 as cited in Barnett & Fry, 2015, p. 271). The use of solely a biochemical explanation for substance use has been described as dangerous and oversimplified (Sanders, 2007, p. 62) and ignores social, cultural, historical and environmental context. Barnett and Fry (2015) also argue that constructing substance use in this manner in practice could lead to clients feeling, “a sense of permanent disempowerment leading to clients feeling helpless” (279). Constructing substance use in this way seems fairly unhelpful in practice. I am left wondering how you would support the motivation for change if you were also telling someone that they are going to have a chronic disease, which is part of their biochemical make-up?

Viewing substance use in this way also influences ideas about treatment options. Brown, Stewart and Larsen (2009) argue that using a disease model has serious implications, which lead to a lack of choice, control, and agency:

Addictions are thus conceptualized as an all-or-nothing phenomenon where- by one either has, or does not have, the disease of alcoholism and from which less severe forms of drinking, such as problem drinking, or binge drinking/episodic drinking are indistinguishable (Marlatt et al., 1993). From this traditional deterministic perspective, alcoholism is a genetic or biologically caused disease outside of individuals’ control, necessitating abstinence-based treatment. (p. 97)

This is problematic given that we know harm reduction can lead to positive outcomes in women (Brown & Stewart, 2007).

Many participants presented both/and constructions of mental health and substance use, which looked at both biological/biochemical and social, cultural, and historical causes for substance use. Many of the participants made connections between mental health, substance use, trauma, and eating issues. This is well supported in the literature as it has been well documented that there is a strong relationship between these issues in women (Brown, 2013; Covington, Burke, Keaton & Norcott, 2008; Gatz et al., 2007; Pool, 2007; Stewart & Brown, 2007a; Stewart & Brown, 2007b). Stewart and Brown (2007a) describe high rates of eating issues in samples of women accessing treatment for substance use as well as high rates of substance use in women who are accessing treatment for eating issues. They posit that high instances of co-prevalence could be due to:

...a common mechanism or mechanisms involving emotional regulation: namely, that both behaviours might involve common mechanisms of providing emotional rewards (e.g., fulfilling needs and desires) and/or emotional relief from psychological distress (e.g., reduction of anxiety or depression). (p. 161)

Stewart and Brown (2007b) highlight findings in their study on eating issues and substance use, noting that many of the women interviewed reported histories of physical and sexual violence as well as continued trauma experiences into their present lives. They found that many of the women were reporting heavy drinking and binge eating behaviours as a means to cope with previous trauma. Given that higher rates of trauma are present within samples of women who experience co-occurring issues (British Columbia Centre of Excellence for Women's Health, 2009; Brown, 2013; Gatz et al., 2007), it is evident that treatment and intervention should incorporate these factors into

program development. Based on participant responses, it seems that Nova Scotia Health Authority still has a way to go in terms of offering both co-occurring and collaborative treatment as well as treatment that is focused on trauma. This will be expanded on further when discussing participant recommendations.

Making Connections Between Theory and Practice

The findings of this study highlighted the idea that making connections between theory, ideology and practice can be challenging and complex. Often participant responses were demonstrating narratives that grouped theoretical frameworks and practice approaches together. As previously stated in the findings, at times there did not appear to be a concrete distinction between theoretical frameworks or practice approaches or participants would discuss theory in largely practical ways. Payne (2005) argues that theory is often discussed in terms of its application to practice. He contends this does not necessarily work in social work and states that instead, “it is more accurate to see theory and practice having an influence on each other” (p. 26). This could explain, to a certain extent, the lack of distinction between theory and practice in participant narratives. The lack of connection or thoroughness in participant narratives about theory and practice also function as interesting pieces of data. The lack of distinction and elaboration on these topics could suggest that therapists are not placing a lot of thought into these issues in daily practice.

However, I was left with questions about whether or not some of the participants understood the difference between theoretical frameworks and models of practice. Participants were at times vague in describing their use of theory or models of practice. Often times, social workers (or service providers in general) are not engaged in

conversations about theory after leaving their academic programs. Social workers are also often placed in employment contexts that privilege evidence-based models, and therefore certain language practices and terminology may become the norm. I often hear social workers describe their practice using ‘buzz words’ such as – client-centered, strengths-based, holistic and narrative. It leads me to wonder if they are describing their practice in ways that simply sound good. Does everyone describing their practice in this way, know what they mean when they speak to engaging in ‘trauma-informed’ or ‘strengths-based’ practices? Do they know where these models or theories are derived from?

Understanding that trauma-informed practices have been informed or guided by feminist perspectives and values (Tseris, 2013) and strengths-based approaches exist within a foundation somewhere in between person-in-environment and humanistic approaches (Gray, 2011) is important. It is important because ignoring theoretical foundations renders the politics invisible. Depoliticizing practice is dangerous as it allows us to maintain and reinforce dominant discourses. Strengths-based approaches have been highly criticized as being more in line with medical models of practice that have pathological ideas about helping (Morley, 2003). Another example is empowerment theory. Fook and Morley (2005) argue that because of its popularity, it can be misinterpreted and misconstrued into a ‘single concept’ rather than a theoretical concept derived from critical and structural theories (p. 67).

Payne (2005) argues that theory is inherently political given it is used to justify certain methods of practicing or ways of being. For social workers, theory is related to accountability and I would argue that the use of theory in practice should be thoughtful and intentional. Eclecticism allows practitioners to not have to account for what they are

doing. Given that all of the participants drew on a number of theoretical and practical models, Payne (2005) cautions the use of eclectic models of practice by stating that:

Because of the danger of confusion in combining and adapting theories, if we pick up the ideas from different places, it is important to be aware of the sources, values, methods, and objectives of the basic theories we are borrowing from, and prohibitions and encouragements to combination with other ideas. (p. 31)

Staub-Bernasconi (2009) argues that one position can sometimes be that, “the only possible approach to theory building in social work is an eclectic one, in the sense that ‘anything goes’ as long as it ‘works’ (p. 11). She reasons that this position is reinforced through some, “postmodern, epistemological theories, which rely on a consensual theory of truth, but also by neo-liberal approaches” (p. 11).

Eclecticism is extremely common in social work and clinical practices. A study done by Pignotti & Thyer (2009) outlining therapies used in clinical social work, reported that eclecticism was the ‘theoretical orientation’ most often reported by social work clinicians. Eclecticism can be useful in providing interventions that align with client ‘problems’. Not every approach may be a fit for every person and having the knowledge, skill and ability to use eclecticism in intervention and treatment is useful. I would also argue it is necessary that one’s overall approach is firmly grounded in a theoretical orientation (i.e., one’s theory can be feminist-based and anti-oppressive while providing interventions that align with narrative, solution-focused, and mindfulness). Consistent with participants narratives, theoretical orientation or the basis of how one engages with clients, should not change.

Barriers To Practice and Institutional Ideology

The systems in which treatment for mental health and substance use reside in are rooted in reductionism, essentialism and patriarchy. This was evident in the narratives of participants as all of them provided a critique of dominant discourses around women's experiences (i.e., increased stigmatization due to sexism, inaccessible and unsafe treatment options, treatment of women by service providers, etc.). Brown (2009) argues that using the medical model as a basis for your framework allows for trauma to exist as an afterthought in the presence of mental health and substance use. If substance use or mental health is separated from the context of women's lives it is often reduced to simply a disease or an illness. This is problematic because the issues become individualized and an analysis of oppressive systemic structures is lost. It also ignores environmental stressors and how mental health and substance use can be secondary responses.

One finding that was prevalent in participant stories was the critique of pathological language used in the description of women and the issues they are experiencing. Participants critiqued the use of language that was judgmental, punitive and medicalized. Despite having a critique of the language and engaging in critically questioning dominant discourses in their work, many of the participants engaged in language firmly grounded in pathology and medical discourse (e.g., manipulative, patient, illness, disorder, etc.). This is consistent with Brown's (2001) finding related to the use of medicalized language practices by feminist based practitioners. She highlights this finding by stating:

One might imagine that feminist therapy would typically be critical of the disease model, and the institutional practices of psychiatry, this stance is less predominant

than are the efforts to rid therapy of sexist bias within the existing system. The therapists interviewed strive to depathologize women's experiences and typically reject a disease model, yet they no longer hesitate to refer to labels such as "multiple personality disorder", "borderline personality disorder" or "eating disorders".

A few of the participants interviewed in this study used psychiatric labels such as "borderline personality disorder", "bipolar disorder", and "mental illness." Likely being immersed in an organizational (and societal) culture that privileges dominant ideas about mental health and substance use relating to DSM descriptions of women's issues, lead to the (perhaps unconscious) engagement in language that can be both pathologizing and oppressive. It is also possible that participants feel some degree of oppression within their organizations and feel that they must engage in these language practices in order to be accepted or advance in their positions.

Participants in this study also critiqued the lack of collaboration between Mental Health and Addiction Services despite the amalgamation in 2012. At the time of the interviews, participants (for the most part) reported that there had not been significant changes translating into front line services. This finding is consistent with the literature outlining significant barriers in accessing and navigating separate treatment and service systems (Anthony, Taylor, & Raffo, 2011; Drake et al., 2001; Stewart, 2009). Although the Nova Scotia Health Authority Mental Health and Addictions Program has made fairly significant changes over the last few years (see A Collaborative Framework - Caring for Individuals Living with Concurrent Disorders, 2011; Addictions and Mental Health Quality Program Annual Report 2013-2014; and Together We Can Progress Update

2016), it is still unclear how women (or anyone) experiencing co-occurring issues such as trauma, eating issues, substance use, and mental health are able to access holistic integrated treatment that is supportive, appropriate and safe. To my knowledge, there is still no formalized integrated treatment option available under the Nova Scotia Health Authority despite years of advocacy and good work being done on behalf of some community clinicians. There is also no mention, in the previously referenced reports, of trauma, socio-political context, or gender-specific programming for women in working with co-occurring issues. Perhaps the resistance associated with institutionalizing gender-specific integrated programming is a reflective of a larger societal discourse around what kind of treatment is privileged over others (i.e., due to patriarchal and sexist values).

Many of the participants cited clinician training as a barrier for service providers, which is consistent with literature on service provider narratives, and barriers (Blakely & Dziadosz, 2007; Drake et al., 2001). Participants felt that more training across mental health and substance use would be necessary to provide better service provision. Only one of the participants spoke to online training being offered across the Mental Health and Addictions Programs in HRM. The training mentioned, refers to the provincial Concurrent Disorder Toolkit that was rolled out in September of 2014. As of January 2016, the Together We Can Progress Update stated that 250 employees (e.g., social workers, nurses, and psychologists) have completed it. It consists of nine learning modules based on the core competencies for working with co-occurring mental health and substance use issues (Leduc, 2014). The nine core competencies were cited as being:

(1) Understanding concurrent disorders; (2) Identifying concurrent disorders; (3) Screening and assessing next steps in treatment; (4) Understanding medications and

substances of abuse, and interactions in concurrent disorders; (5) Recovery, harm reduction, peer support, and motivational interviewing/engagement; (6) Best practices for treating CD; (7) Preventing relapse and maintaining optimal mental health; (8) Assessing risk and intervening in crisis; (9) Information sharing and circles of support.

Providing training for service providers in both Mental Health and Addictions is an important step in moving towards more simultaneous treatment of co-occurring issues. Having deeper understandings of how to work with mental health and substance use is invaluable. It will be interesting to see the feedback on how supportive the training has been in providing information on how to work with co-occurring issues as well as whether or not it has facilitated “greater collaboration” (Together We Can Progress Update, 2016). That being said, there are academic critiques of competency-based movements stating that often times there is confusion around the language and definition of ‘competency’ and whether it speaks to specific knowledge, skills, abilities, or activities (Cate & Scheele, 2007).

I am still left wondering about what the ‘best practices’ entail for working with co-occurring issues in Nova Scotia. There is a Nova Scotia report detailing System Level Standards for Concurrent Disorders (2012) that outlines recommendations and improvements to current programming through standards and objectives. One of the guiding principles of the report is “evidence-based” (p. 6). Although this concept is defined in the report, I am still left with questions about what exactly it means in terms of intervention. It may be based on Health Canada recommendations for best practices for co-occurring issues given that the Health Canada report emphasizes using evidence-based

in three main areas: identification, assessment and treatment (see Health Canada Report – Best Practices: Concurrent Mental Health and Substance Use Disorders, 2002).

Some of the participants in the study critiqued the enforcement of ‘evidence-based’ practice in their workplaces. There was a feeling that perhaps client care was more about providing evidence-based treatment as opposed to what works best for clients. This creates a ‘one size fits all’ outlook on service provision. Although there is an abundance of literature suggesting evidence-based practices provides the most positive client outcomes (Drake et al., 2001), it is clear that certain models of treatment seem to be privileged over others (i.e., through both funding and research, which would lead to the classification of evidence-based) (Teghtsoonian, 2009).

Generally evidence-based models of treatment are easily translated into training, rooted in brief treatment, and provide cost-effective options (Esposito & Perez, 2014; Teghtsoonian, 2009). When considering evidenced-based practices, it may be important to contemplate whether or not these modalities are being chosen because they are easily packaged or measured. This raises the issue of how exactly evidence-based research is being measured. There is literature that suggests that treatment validity for evidence-based practices may have been “inappropriately constructed and analysed – and therefore misconstrued - before being reified in influential treatment guidelines” (Parker & Fletcher, 2007, p. 357).

Another organizational barrier discussed by participants, similarly to evidence-based practice, was the implementation of brief treatment models in Mental Health and Addictions Services. There are potential benefits to brief treatment including minimizing waitlists and providing cost-effective treatment. Roche and Freeman (2004) argue that,

“brief interventions are also highly cost-efficient due to the minimal cost of the intervention” (p. 11). Advocates of brief treatment would state that there is an abundance of evidence suggesting that brief therapy is very effective (Roche & Freeman, 2004). Using feminist based or trauma informed brief interventions could be helpful working with women in emergency or crisis settings (British Columbia Centre of Excellence for Women's Health, 2009). However, participants were critical about the appropriateness of brief treatment models when providing therapy, especially with women experiencing trauma histories. It would be difficult to fully unpack those kinds of narratives within six 50-minute sessions. This is consistent with literature suggesting that women may not receive the same benefits as men in brief treatment models (Bien, Miller & Tonigan, 1993). Given that brief treatment was not appropriate for some of their clients, many of the participants told alternative stories of resistance to these policies and navigation around them in order to advocate for client needs.

In the construction of co-occurring issues in women, participants also reported a number of gender-specific barriers that women experience in comparison to men (i.e., increased rates poverty, lone-parenting, social-contexts, stigma, etc.). Participants spoke to a lack of resources experienced by women related to transportation, childcare, safe housing. These findings are consistent with literature on women experiencing co-occurring issues (Brown, 2009; Brown & Stewart, 2008; Gose & Jennings, 2007). They also outlined intimate partner and sexualized violence, which is experienced at disproportionately high rates by women (Kang, 2007; Pottie & Locke, 2000). Many of these factors contribute to high dropout rates for treatment. This is related to another finding of this study, indicating limited treatment options is both a barrier for women

seeking treatment and service providers' ability to provide treatment. Service providers discussed feeling limited in terms of the treatment they can offer due to policy, procedures, and prescriptive methods of dominant practice. Taking these factors into consideration and implementing programs that addresses the complex lives of women may support more positive outcomes (Courbasson, 2007).

Participants also reported high rates of shame, self blame and lack of self worth experienced by women in this population. This is consistent with current literature on women experiencing co-occurring issues such as mental health, substance use, trauma, and eating issues (Brown, 2009; 2013). Dominant discourses around trauma, mental health and substance use shape women's experiences leading to these experiences. Women are consistently facing situations where they are criticized, stigmatized, judged and blamed for their experiences, especially with regards to trauma and substance use. By providing an analysis of these dominant stories about women, service providers rendered visible alternative or counterstories of women's experiences. I would argue that some participants were telling stories about practice that highlight White's (1994) ideas about, "interacting with persons in ways that assist them to identify, to embrace, and to honour their resistance to those acts of self-government that they are incited to engage in by the dominant knowledges and practices of power of this modern culture" (p. 2).

In working with women experiencing self-blame, Brown (2013) argues that, "unless women's stories are unpacked, the self-blame and helplessness within dominant or privileged narratives are simply reconstituted" (p. 24). Given the belief that therapy is inherently a political process that is not exempt from the, "politics of gender, class, race and culture" (White, 1994, p. 1), having a socio-political analysis in therapeutic practice

provides an avenue to begin having conversations about mitigating dominant stories and privileging alternative ones.

Service Provider Recommendations

In continuing the conversation around having a socio-political analysis, many participants in this study identified and recommended the use of a feminist perspective or analysis. Worell and Remer (1992) state that using a feminist analysis allows us to view women in specific ways:

Women have individual problems because of living in a society that devalues them, limits their access to resources and discriminates against them economically, legally, and socially. Thus, sexism is institutionalized in all areas of our society - families, religion, education, recreation, the work place, and laws.
(p. 90)

Feminist perspectives and analyses in therapy or treatment can challenge harmful dominant discourse perpetuating the pathologizing of women's bodies and experiences. They challenge the patriarchal assumptions focused on women's roles in society and reinforces alternative stories about women experiences. Viewing women's stories through a feminist and critical lens allows for stories of manipulation and victimization to become ones of empowerment and resistance. Some of the service providers in this study engaged in counterstories that looked at women's experiences contrary to dominant patriarchal discourses. Jacqueline (study participant) does this by being, "really aware of all those mixed messages that women can get when they walk into like a professional organization like addictions."

Using a feminist analysis in therapeutic relationships provides a means for negotiating power and control between service providers and services users. Brown (1993, p. 176) argues that, “a heightened awareness of, and responsible use of power in the therapy relationship is central to the process of feminist therapy and feminist ways of working.” This allows for the focus to be on empowerment and self-determination, which is especially important in working with women who have histories of mental health and trauma. Often these women relate experiences of a lack of control and a sense of powerlessness, which promotes the use of secondary responses such as harmful eating practices and substance use.

There were a number of organizational recommendations previously discussed such as increasing clinician training to increasing communication and collaboration between Mental Health and Addictions programs. It has been well documented that providing integrated treatment leads to more positive client outcomes (Drake et al. 2001; Drake et al., 2004; Health Canada, 2002; Peralta & Jauk, 2011; Skinner, 2005; Stewart & Brown, 2007a). Stewart and Brown (2007a) suggest that:

In many areas of addictions, integrated treatment packages are currently being developed, where treatments are applied to co-occurring problems simultaneously rather than sequentially. In general, such combined treatments appear to be very effective for those who are able to complete the treatment. However, dropout rates tend to be extremely high (see review by Conrod & Stewart, 2005). (p. 359)

The findings of this study were also consistent with the literature supporting the need for the consideration of trauma histories when providing treatments and interventions (Brown & Stewart, 2008; Covington et al., 2008; Koehn & Hardy, 2007; Krausz, 2009;

Najavits, 2007). Though participants in this study were working in organizations that largely viewed trauma and women's experiences through dominant discourses of pathology and behaviour, the services providers told counterstories of engaging with women in ways that were focused on unpacking women's experiences of shame, self-blame, and stigmatization.

Many of the participants stated that gender-specific programming has been and would be supportive in addressing dropout rates and increasing safety. A few of the participants acknowledged structural issues with the Withdrawal Management Unit in Addictions Services, given women are reporting that they do not feel safe in that space due to mixed-gender treatment. This is consistent with literature suggesting that, "gender and sex specific treatment approaches have proven to be more efficacious than mixed gender groups," (Peralta & Jauk, 2011, p. 889). Research has shown that women are at greater risk of developing PTSD than men (Najavits, Weiss & Shaw, 1997). Brown, Stewart and Larsen (2010) state that treatment for women should take these into consideration:

...gender-specific barriers to treatment including health risks, biology, social contexts in which addictions occur, and the social consequences of having a drinking problem (i.e., having one's children placed in care). Subsequently, their treatment needs are markedly different than men's. In addition to developing drinking problems with lower alcohol intake than men and experiencing greater health risks, overlapping issues of eating disorders, depression, sexual trauma or abuse, and domestic violence suggest the need for comprehensive and overlapping treatment for women. (p. 107)

Gender-specific programming could provide increased accessibility for women given it would take into consideration needs such as childcare or children's school schedules. It would also provide spaces for treatment that may feel safer than treatment sites that provide services to individuals identifying as male. This has been reported in literature arguing that women feel safer in groups with other women where they can openly discuss violence and abuse (RachBeisel, Scott & Dixon, 1999). This could especially be true for residential treatment.

Implications for Social Work Practice

There are a number of potential implications for social work practice that could be derived from this research. It was clear that more collaboration, communication and training across Mental Health and Addictions Services is important in working with clients who experience these issues. Further, women who experience these issues often experience eating issues and have a history of trauma. Understanding trauma-specific approaches is necessary for working with women with these issues.

This study has lead me to believe that perhaps social workers should be having conversations about theory and practice after graduation. Often these concepts are discussed in educational programs and then forgotten upon attaining employment. Engaging in these conversations promotes accountability in social work practice. It also promotes critical reflective and reflexive practices.

This study has also highlighted the importance of engaging in conversations about organizational and institutional ideology. Given the belief that language cannot be neutral and always is socially constructed through dominant discourse, having an ability to unpack pathologizing language in practice is important. Using labeling or judgmental

language affects the way we view and work with women, specially women who are multiply marginalized and experience issues such as mental health and substance use. These kinds of language practices reinforce feelings of shame and self-blame. Having socio-political (feminist) analysis when working with women experiencing mental health, substance use, trauma, and eating issues is imperative in order to understand the structural, cultural, historical and environmental complexities impacting women's experiences.

CHAPTER SIX: CONCLUSION

Summary

The purpose of this study was to gain a deeper understanding of the experiences of service providers in Nova Scotia who are working with co-occurring mental health and substance use issues in women. One of the primary goals of this research was to contribute to the discussion of knowledge and practice-related theory associated with understanding how those who work in this field understand the relationship between concurrent issues as well as how they work with implementing intervention approaches, specifically looking at practice approaches with women. The rational for conducting this study involved a number of different factors including: individuals with co-occurring mental health and substance use issues have continuously come into contact with a mental health system that has historically been developed separately from those that address substance use issues; in recent years the provincial government of Nova Scotia has introduced a strategy to amalgamate mental health and addictions services in order to improve province wide service provision; and research has shown clients with co-occurring mental health, substance use, and trauma are more successful in treatment when they are addressed simultaneously (Blakely & Dziadosz, 2007; Drake et al., 2001; Drake, Mueser, & Brunette, 2007; Ford-Gainer, 2009; Jaynes, 2008; Krausz, 2009; Schütz et al., 2013; Skinner, 2005; Halfpenny-Weir, 2009).

The introductory chapter of this study outlined the framework and provided context for the research topic. It included information pertaining to co-occurring mental health and substance use in Nova Scotia as well as an introduction into the Mental Health and Addictions Strategy. Chapter Two provided a review of relevant literature pertaining

co-occurring issues in women. It outlined topics such as: conceptual approaches to language; the relationship between mental health and substance use; integrated treatment approaches; women-centered treatment for co-occurring issues; service provider narratives; and barriers to treatment, both for women experiencing co-occurring issues as well as service provider identified barriers to providing treatment. The third chapter discussed the studies qualitative research design using narrative inquiry. This study recruited six graduate level social workers, participating in therapeutic relationships with women with co-occurring issues, using purposeful snowball sampling methods. In-depth semi-structured interviews were conducted and the data was then analysed through thematic and discursive methods of analysis.

Chapter four discussed the findings of the research, which was explained through five main themes: service providers' understanding of the relationship between mental health and substance use; participant connections between theory and practice, the development and description of participants ideology; barriers to service provision; and recommendations for change. Participant stories reflected the complex nature of understanding the relationship between mental health and substance use and reported engaging in highly eclectic models of practice to work with women experiencing these issues. Study findings suggest that participants believed collaborative or integrated treatment models, that are trauma specific, would work best for women with co-occurring issues. Findings also suggest that primary barriers to service provision include oppressive organizational ideologies, issues with program structuring, and sexism and stigma experienced by women accessing these services. Chapter five provided an analysis of the findings exploring more in-depth the use of eclecticism in social work practice as well as

the current literature and debates exploring the relationship of co-occurring issues as well as etiology. The analysis also further explored literature around evidence-based practice and brief treatment models. Implications for social work practice include the suggestion that incorporating more education around co-occurring issues, especially in women, may be helpful to increase understanding and ability. I argue that there should be an emphasis in social work education and practice around the importance of grounding oneself in a theoretical orientation. This provides the knowledge and justification in order to support why you are using certain methods or interventions. Using a socio-political analysis when working with women experiencing mental health, substance use, trauma, and eating issues is imperative in order to understand the structural and environmental complexities impacting women's experiences.

Strengths and Limitations

Narrative Research

This study had a number of both strengths and limitations related to the method of research. Given that stories are primarily constructed within the context of dominant discourses (Brown, 2013), narrative inquiry allows for the exploration of service provider narratives within the dominant institutional discourses in which they practice from while providing an avenue for them to account for the ways in which they challenge and resist dominant ideology. Avdi (2008) states that, “ conversation, discourse, and narrative analysis all share a focus on meaning and on the constructive function of language.” (p. 70). Narrative research provides an avenue for ‘real life’ experiences to be explored and explained in meaningful ways (Connelly & Clandinin, 1990). Although narrative inquiry provides a congruent methodology to qualitative research positioned in constructionist,

feminist and postmodern perspective, Clandinin (2006) argues, “for those of us wanting to learn to engage in narrative inquiry, we need to imagine ethics as being about negotiation, respect, mutuality and openness to multiple voices.” (p. 52). Narrative inquiry is highly complex and subjective. Riessman (2003) warns of the dangers in, “over-personalising the personal narrative” (p. 6) by professing an idealized and subjective truth through an ‘authentic’ voice (p. 6).

Researchers must be mindful in the exploration of participant narratives so as to not assign meaning to their lived experiences. In order to resist this, researchers should likely be continually checking-in with participants and asking clarifying questions. Given the position of the researcher is inherently privileged, narrative researchers must remain mindful of their own presence in the research and the power dynamics involved (Potts & Brown, 2005). Narrative researchers are tasked with making decisions about which parts of participant stories are omitted, when the researcher’s voice is heard and whose voices are dominant. Another critique is that researchers may suppress certain stories and favour others in order to support their own ideas about the subject matter.

Transferability

Given that generalizability is not the goal of qualitative research, small sample sizes are common. However the methodology may also contribute to the lack of transferability given that the explorations of narrative research are so subjective. Additionally, the participants themselves may affect the studies ability to be transferable. Participants were working in different environments and only four were working within the Nova Scotia Health Authority (there was only one participant who was truly engaged in therapeutic practice within mental health services at the Nova Scotia Health Authority

and they were strongly positioned in feminist-based practice). Interviewing more participants from both formal mental health and addictions services would have been helpful in capturing the experiences of clinicians in this organization.

Sampling

Purposeful and snowball sampling methods led to clinicians who either had some association with myself (i.e., either work or school) or who were drawn to the subject matter. Many of the clinicians identified with feminist practice and therefore are more likely to question dominant discourse and ideology present in their organization or our formal systems. Additionally, all of the participants were white women with graduate level degrees. Service provider experiences and understanding may have looked different with a more diverse sample. It is impossible to know whether or not their views are representative of the norm of clinicians working with women who experience these issues.

Participant Interviews

Being able to look back and critically reflect on the interviews, there were instances that important questions were missed or concepts were not explored as in depth as they could have been. For example, I could have asked more deconstruction questions in order to further unpack concepts related to theory, practice, and perspectives. Having a deeper understanding of exactly how participants engage in their practice would have been helpful in producing thicker narratives (i.e., ‘what does narrative therapy look like for you when you work with women?’, ‘what does feminist therapy look like when you work with women?’, ‘what does a client-centered model look like in your practice?’). I think there were also missed opportunities in terms of unpacking participants

understanding of the relationship between mental health and substance use. For example, I could have asked more clarifying questions about their understanding of etiology (e.g., ‘do you think substance use involves a genetic predisposition or biochemical factors?’, ‘do you think mental health issues come originate more from a genetic predisposition or a social or historical origin?’). I also would have liked to further unpack participant stories around language. Many of the participants critiqued medicalized or pathological language or discourse but also engaged in the use of the language (e.g., ‘why would you chose mental illness as opposed to mental health issue?’, ‘what do you think the difference is between using the word issue versus disorder?’, ‘what do you think it means to use the word patient versus client?’).

Areas of Further Exploration

It could be beneficial for future research to focus on widening the scope of this study to include a large number of service providers engaging in therapeutic work in Nova Scotia (both from within the Mental Health and Addictions Program at the Nova Scotia Health Authority and from the community). Having a wider understanding of how we understand co-occurring issues in women and how we work with them in our practice is extremely beneficial for policy and program development. It can also inform the kinds of education and training necessary to support service providers in their practice and users in accessing services. Uncovering dominant and alternative narratives in women who are accessing these services in Nova Scotia could be beneficial in an in-depth exploration of barriers they are identifying in terms of clinician attitudes, intervention and accessibility.

It may be interesting to explore service provider experiences with the online training tools provided through the Nova Scotia Health Authority on co-occurring issues. Were these tools helpful in creating more collaborative relationships between services? Did they support clinician's ability to offer integrated services? Did they include gender-specific and trauma-specific components?

Final Reflections

Having the privilege to conduct this research has proven both challenging and rewarding. It has reaffirmed my desire for working with women from a feminist, critical and post-structuralist framework. Having the opportunity to engage with clinicians working in this field was immensely supportive of my own growth and learning as a practitioner. I am fortunate that I have the opportunity to engage in the relationship between theory and practice on a daily basis in my employment and I hope to continue to learn and grow both academically and professionally.

Everything we do in life is rooted in theory. Whether we consciously explore the reasons we have a particular perspective or take a particular action there is also an underlying system shaping thought and practice. (Hooks, 2000, p. 4)

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APPENDIX A: Informed Consent Form



CONSENT FORM

Project Title: A narrative exploration of service providers' understanding of the relationship between co-occurring mental health and substance use **issues among women in Nova Scotia.**

Lead researcher: Sarah Oulton, MSW Student, Dalhousie University School of Social Work, Email: sr592817@dal.ca

Supervisor: Catrina Brown, Associate Professor, Dalhousie School of Social Work Tel: (902) 494-7150,
Email: catrina.brown@dal.ca

In order to receive more information or clarification about the study at any time, or to report any potential difficulties related to the research, please contact at the following:

Sarah: (902) 489-1677 or sr592817@dal.ca

INTRODUCTION

You are invited to take part in a research study being conducted by Sarah Oulton who is a Master's of Social Work student at Dalhousie University. Taking part in the research is up to you; it is entirely your choice. Even if you do take part, you may leave the study at any time for any reason. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience. Participating in the study might not benefit you,

but we might learn things that could benefit others.

Please ask as many questions as you like. If you have any questions later, please contact the lead researcher.

PURPOSE OF THE STUDY

The purpose of this research involves gaining an in-depth understanding of the experiences of service providers in Nova Scotia who are working with co-occurring mental health and substance use issues. This research will contribute to the discussion of empirical knowledge and practice-related theory associated with understanding how those who work in this field understand the relationship between concurrent issues as well as how they work with implementing intervention approaches. The hope is that this study will contribute to the discussion on how front-line mental health and addiction service providers are working with and implementing the new Mental Health and Addictions strategy in Nova Scotia.

STUDY DESIGN

As a participant in this study, you will be asked to share your knowledge of working with women who experience mental health and substance use issues. This information will be collected in one-to-one interviews lasting about 60 minutes. You will only be asked to participate in one interview at a confidential location of their choice and convenience. The interviews will be looking for information on how service providers understand the relationship between co-occurring mental health and substance use issues among women, as well as their use of theoretical frameworks and subsequent practice approaches in this field. This study is hoping to have 6-10 service providers participate. A final report of the study will be available for participants upon completion of the project.

WHO CAN PARTICIPATE IN THE STUDY?

You may participate in this study if you are a service provider who has worked with women experiencing co-occurring mental health and substance use issues. This study will primarily consist of master's level social workers that are currently working in the field of mental health and addictions.

WHO WILL BE CONDUCTING THE RESEARCH?

The primary researcher in this study is graduate student, Sarah Oulton. Their supervising professor is Dr. Catrina Brown at the School of Social Work. Only the primary researcher will be conducting and transcribing the interviews and only the above mentioned researchers would have access to the data transcripts.

WHAT YOU WILL BE ASKED TO DO

First I will be asking you to fill out a short demographic questionnaire looking for information on your identity, age, education, and employment. I will then be asking you a few questions around your narrative accounts of working with women who experience

co-occurring mental health and substance use issues. I will also be asking a few questions about your understanding of the relationship between mental health and substance use as well as the intervention approaches you use in working with women who experience these issues. Aside from basic demographic information (e.g., age, gender identity, race, education and training, etc.), you will only be asked questions related to your theoretical and practical understanding of your field. You will not be asked about your personal experiences or life situations outside of your theoretical and practice approaches. The interview should take no more than 60 minutes (plus about five minutes to fill out the demographic questionnaire). I would like to audiotape the interview with your permission. I will carry out the interviews at a place of your choosing.

POSSIBLE RISKS AND DISCOMFORTS

The risks associated with this study are minimal. In participating in this study you could potentially feel some discomfort in discussing certain topics in relation to their understanding or practice approaches in working with co-occurring mental health and substance use issues. You could also experience discomfort after the interview if you feel you have shared too much personal or organizational information. You will be treated with respect, dignity, and sensitivity at all times. There will be time spent at the end of each interview, unrecorded, to debrief around any comments or concerns. If you are experiencing emotional distress, the interviewer will be prepared to refer to counseling and support if desired.

POSSIBLE BENEFITS

The benefit of this study is that you will be sharing accounts of your experiences working with co-occurring mental health and substance use among women. The knowledge from these experiences may contribute to the growing body of research around integrated and women-centered treatments for co-occurring mental health and substance use. Further, this research could contribute to the lack of research and information on this topic for Nova Scotia. Participants in this study as well as other community and health care professionals within this field may gain some insight into how their colleagues understand and work with these issues. This insight could spark agency discussion around education, training, and program development. Finally, this study may provide some front line knowledge into how the Mental Health and Addiction Strategy in Nova Scotia is being implemented and carried out.

COMPENSATION / REIMBURSEMENT

You will not be compensated or reimbursed for time in this study.

CONFIDENTIALITY & ANONYMITY

You will not be anonymous to the researcher but anything you say will be kept secure and confidential. The researcher will know the identity of the participants during the interviews and though the interviews will be given a code number and each participant assigned a pseudonym, the researcher will have access to each participants identifying

code. Each interview will be digitally audiotaped and identified with your code number. Each code number will then be linked to a pseudonym for the participant. Your name will not appear on the digital recording file or the transcript (just your pseudonym) and these files will be password protected. The research team will be the only people to have access to the transcripts. The digital audiotape will be erased once transcripts have been completed. The Informed Consent Form and the transcripts will be stored separately in locked filing cabinets. Data must be kept on file for 5 years as stated in Dalhousie University research policy, and will be stored in locked cabinets in the office of the supervising Professor, Dr. Catrina Brown, after the study is completed. In reporting the findings (i.e., through presentations, reports, or publications), all names and any characteristics that might identify participants will be removed (i.e., name, age, ethnicity, agency, department, etc.). At the end of five years, all data will be shredded. There are a few limits to confidentiality due to legal obligations. We will be unable to maintain confidentiality in the case disclosure is necessary to prevent serious, foreseeable and imminent harm to you or others. The researcher has a duty to disclose suspected child abuse or neglect, or the abuse or neglect of an adult in need of protection to the Department of Community Services.

IF YOU DECIDE TO STOP PARTICIPATING:

You are free to leave the study at any time. If you decide to stop participating at any point during the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information (e.g., if you decide to stop interview). You can decide for up to one month after the interview to have your data removed. After that time, the report may already be written and submitted. You will have three months in total after the interview to decide to remove your data before potential publication.

HOW TO OBTAIN RESULTS:

I will provide you with a final report on group findings when the study is finished. No individual findings will be provided. You can obtain these results by contacting the primary researcher in approximately six months.

QUESTIONS

If you have any questions or concerns at any time you would like to discuss with the researchers, please contact Sarah at (902) 489-1677 or sr592817@dal.ca. You may also contact Dr. Catrina Brown at (902) 494-7150 or catrina.brown@dal.ca. You will be provided with any new information that might affect your decision to participate in the study. You will receive a copy of the consent form at the outset of the study for your records. **Participation is voluntary. You may withdraw your participation at any time.**

PROBLEMS OR CONCERNs

If you have any ethical concerns about your participation in this research, you may also

contact the Director, Research Ethics, Dalhousie University at (902) 494-1462, or email:
ethics@dal.ca

INFORMED CONSENT FORM

A narrative exploration of service providers' understanding of the relationship between co-occurring mental health and substance use issues among women in Nova Scotia

SIGNATURE PAGE

"I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study and agree to be audiotaped. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time."

I agree to allow direct quotations from my interview to be used yes no

Participant's Signature

Date

Researcher's Signature

Date

APPENDIX B: Recruitment Script

Dear _____,

[My name is Sarah Oulton and] I am currently completing a thesis project for my Master's of Social Work degree. I am writing to invite you to participate in the study I am conducting under the supervision of Dr. Catrina Brown at the Dalhousie School of Social Work. I am looking to talk with service providers, primarily those with an MSW background, about their understanding and practical approaches to working with women who experience co-occurring mental health and substance use issues. I am looking to do individual interviews that will take about an hour. These interviews would be completely private, confidential, and non-judgemental. The interview can occur in a place of your choosing that is both comfortable and convenient for you. If you have any questions or feel you might be interested in participating in this research please contact me through email: sarahoulton@dal.ca or phone: (902) 489-1677. Additionally, if you have any colleagues you feel might be interested in participating in this research it would be much appreciated if you could forward this email onto them. Thank-you for taking the time to read this email and consider the invitation. I hope to hear from you.

Kind Regards,

Sarah Oulton
BSW, MSW(c), SWC

APPENDIX C: Demographic Questionnaire

Demographic Questionnaire

Identity

1. How do you identify your gender? _____
2. Do you identify as Lesbian, Gay, Bisexual, Transgendered, Two Spirited, Queer, and/or Intersex (LGBTQI)? _____
3. How would you describe your racial/ethnic identity?

Age

4. What is your age? _____

Education

5. What is the highest level of education you completed?

6. Please list your degree's obtained?

7. Have you completed any other relevant training?

Employment

8. How long have you been working in the field of mental health and substance

use? _____

9. What is the name of the organization you are employed with?

10. What is the name of the department and/or program you work with?

APPENDIX D: Interview Schedule

Interview Schedule

I am meeting with you today to hear about some of your experiences in working with women who have co-occurring mental health and substance use issues. Specifically I am interested hearing more about how you understand co-occurring issues and how you work with them in your practice. Further, I am looking to hear about the theoretical framework or conceptual approach you use in your practice and how that might affect the work you do with women.

I am going to start the interview and ask you some questions on these subjects. If you are feeling uncomfortable at any time, please let me know and we can stop the interview or take a break.

Intent: To explore how do service providers in Nova Scotia understand and work with co-occurring mental health and substance use issues among women?

- A. Service provider narratives of their experiences in working with co-occurring mental health and substance use among women.
 1. How long have you worked in the field of mental health and addictions?
 2. How did you get started in this field?
 3. What interests you about working in this field of mental health and substance use?
 4. What kinds of women's mental health issues have you worked with?
 5. What kinds of women's substance use or addiction issues have you worked with?
 6. What kinds of co-occurring mental health and substance use issues have you worked with?
 7. Is this kind of work something you would like more or less of?
- B. Understanding of the relationship between co-occurring mental health and substance use issues among women
 1. What is your understanding of mental health issues?
 - a. Prompts: ideas, beliefs, cause, prevalence, occurrence, presentation, affects, difficulties associated with, etc.
 2. What is your understanding of substance use issues?
 - a. Prompts: ideas, beliefs, cause, prevalence, occurrence, presentation, affects, difficulties associated with, etc.
 3. What kind of training and/or education have you received related to co-occurring mental health and substance use issues?

4. What is your understanding of the relationship between mental health and substance use?
5. Where did these ideas develop?
6. What is your understanding of these issues among women?
 - a. How do you see these issues as different in women compared to men?

C. Theoretical Framework & Intervention

1. What are your thoughts on working with these issues among women?
2. Do you use any kind of theoretical framework or conceptual approach in your practice?
 - a. Does it differ when you are working with women?
 - b. Does it differ based on the client you are working with?
3. What kind of intervention strategies do you generally use when working with women who experience co-occurring issues?
 - a. Prompt: Do these differ from those you would use if you were only working with mental health?
 - b. Prompt: Do these differ from those you would use if you were only working with substance use?
 - c. Prompt: What is it about these approaches that work for you?
4. How does your understanding of co-occurring mental health and substance use in women affect the intervention strategies or approaches you use in your practice?
5. Does your approach differ when you are working with women compared to when you are working with men?
 - a. If so, how do they differ?
 - b. Why do you think this difference is important?
 - c. Where did these ideas come from?
6. What are your thoughts on individual work vs. group work?
7. Do you generally assign homework to the clients you work with?

D. Barriers

1. What are your thoughts on the barriers service providers face in treating or working with co-occurring issues – specifically among women?
 - a. Prompt: organizational structure, service models, policies, guidelines, outcome measures, clinician ability, etc.
 - b. What about just mental health?
 - c. What about just substance use?
2. What challenges have you faced in working with women with co-occurring issues?
 - a. Prompts: approaches you have wanted to use but have not been able to; time constraints; caseloads; training; etc.
3. What programs (if any) do you find helpful in working with these women?

4. What programs (if any) do you find unhelpful in working with these women?
5. What policies do you find helpful in working with these women?
6. What policies do you find unhelpful in working with these women?
7. Do you see significant changes in the organization since the amalgamation of mental health and addiction services?
8. Do you think these changes have been able to translate into the frontline work you do on a daily basis?
9. What changes would you like to see happen with regards to co-occurring mental health and substance use?
 - a. Specifically among women?

APPENDIX E: Letter of Approval



Research Services

Health Sciences Research Ethics Board Annual Renewal - Letter of Approval

March 11, 2015
Ms Sarah Oulton Health Professions\Social Work

Dear Sarah,

REB #: 2014-3202

Project Title: A Narrative Exploration of Service Providers' Understanding of the Relationship Between Co-Occurring Mental Health and Substance Use Issues Among Women in Nova Scotia

Expiry Date: April 21, 2016

The Health Sciences Research Ethics Board has reviewed your annual report and has approved continuing approval of this project up to the expiry date (above).

REB approval is only effective for up to 12 months (as per TCPS article 6.14) after which the research requires additional review and approval for a subsequent period of up to 12 months. Prior to the expiry of this approval, you are responsible for submitting an annual report to further renew REB approval. Forms are available on the Research Ethics website.

I am also including a reminder (below) of your other on-going research ethics responsibilities with respect to this research.

Sincerely,

A solid black rectangular box used to redact a signature.

Dr. Brenda Beagan, Chair