Public Health Ontario | Santé publique Ontario

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https://www.youtube.com/watch?v=yDSkuRMK79c

Please scroll down this file to view a copy of the slides from the session.

EQUIP Health Care
Equipping Health & Social Services for Equity

The intersections of substance use and gender-based violence: Strategies and resources for Public Health Nurses

PHN PREP JANUARY 14, 2026

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Acknowledging the diversity of lands we live on, and the First Peoples who have stewarded those lands, and our collective obligation to mitigate the ongoing colonial violence against those people and lands.

Content notes

This presentation references gender-based violence, trauma and substance use stigma.

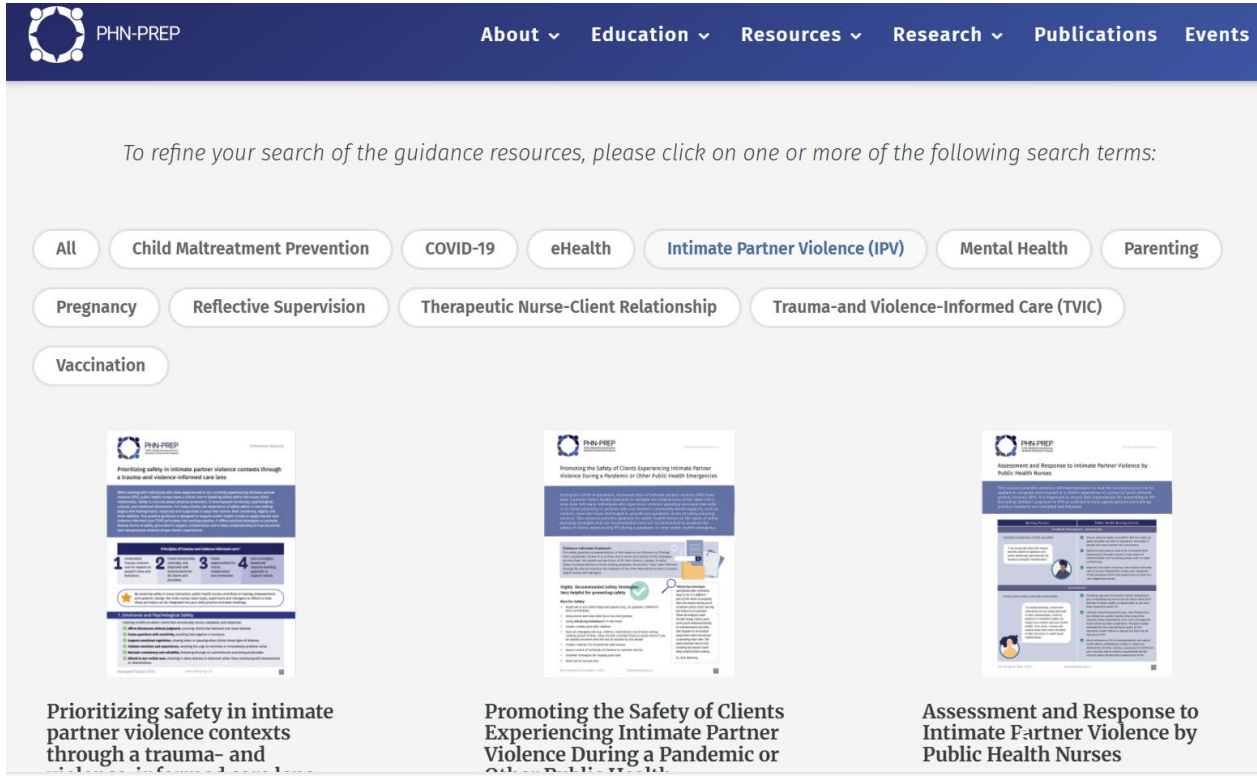
These themes can be difficult, even for those who work in this field every day.

Please engage in ways that feel supportive to you.

Learning Objectives

By the end of this event, participants will be able to:

1. Identify the key dynamics linking gender-based violence and substance use
2. Describe the impact of these dynamics on health and health care, and the implications for public health practice
3. Select resources and tools for use in further strengthening their practice and that of others



Plan

06:30 PST / 09:30 EST - **Introduction**

06:45 PST / 09:45 EST - **Poll** about your knowledge level and confidence

06:50 PST / 09:50 EST - **Animation**

07:05 PST / 10:05 EST - **Foundations**

07:20 PST / 10:20 EST - **Language prompter** and **Nexus module**

07:35 PST / 10:35 EST - Dialogue, Q & A

08:00 PST / 11:00 EST - Adjourn

Research in Violence and Inequity

Studies about Violence

- ER Nursing practice in relation to violence
- Women's experiences of system responses
- Violence/HIV risks for rural and Indigenous women
- What are the health effects of intimate partner violence (BC, ON, NB)?

APP

Can interventions with individual women who have experienced partner violence improve health?

- Pilot ON
- Pilot NB
- Reclaiming our Spirits (BC)
- RCT
- Implementation

iHEAL Intervention for Health Enhancement and Living

Studies about Equity

- What shapes access to care for diverse people (e.g. single mothers, women in rural settings, Indigenous people)?
- What is equity oriented health care?

Can an organizational intervention improve care?

EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

EQUIP Emergency
Research to Equip Health Care for Equity

EQUIP Pathways
Building capacity to end stigma in health care

CIHR IRSC

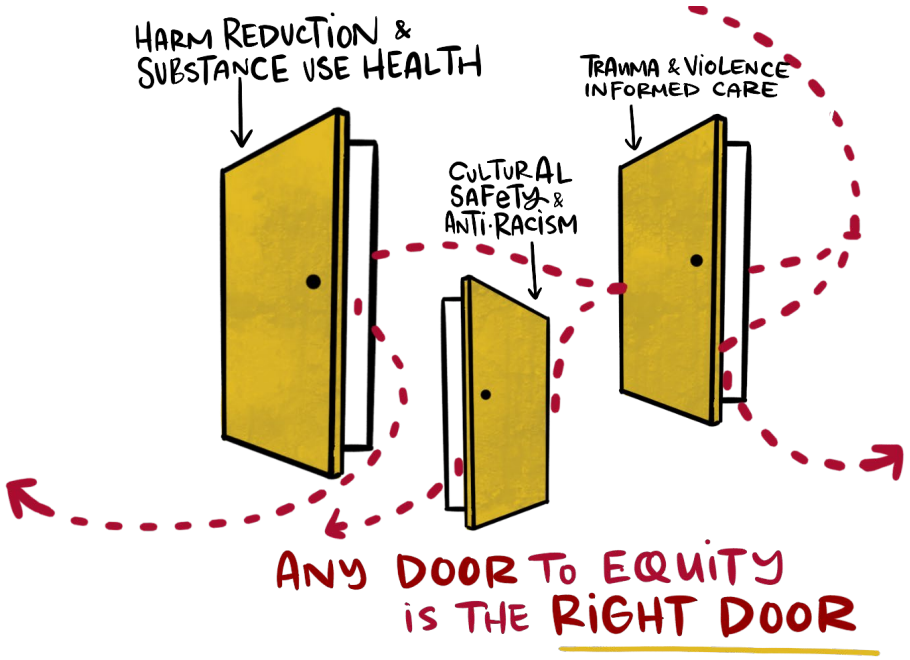
Public Health Agency of Canada | Agence de la santé publique du Canada

Key Dimensions of Equity-Oriented Care

Tailored to context and responsive to inequities

10 Strategies for Equity-Oriented System Improvement

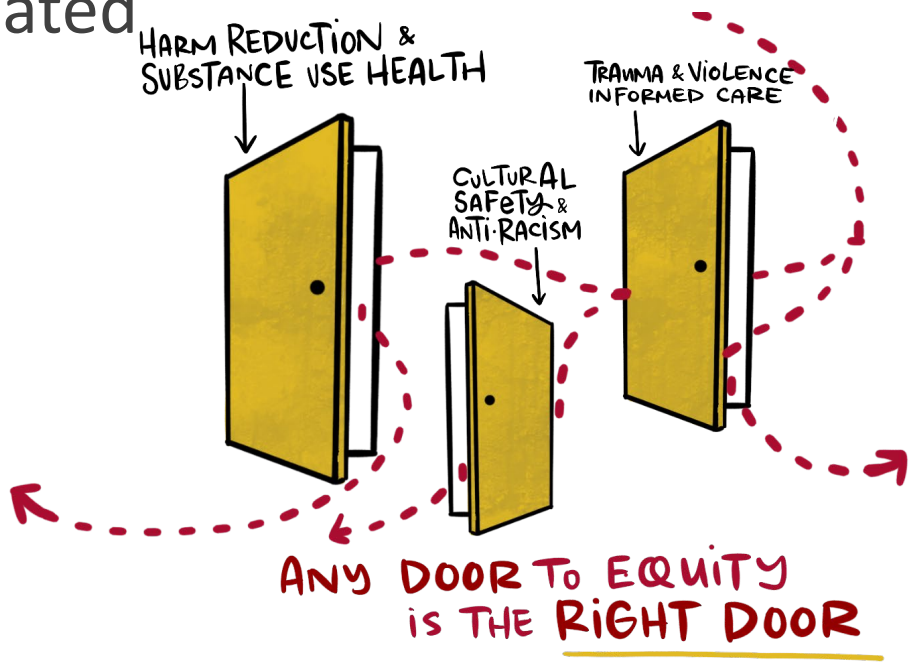
1. Explicitly commit to equity
2. Develop supportive organizational structures, policies, and processes
3. Re-vision the use of time
4. Attend to power differentials
5. Tailor care, programs and services to local contexts
6. Actively counter racism and discrimination
7. Promote meaningful community and patient engagement
8. Tailor care to address inter-related forms of violence
9. Enhance access to the social determinants of health
10. Optimize use of place and space



Challenges at the intersections of substance use and gender-based violence (GBV)

Context: widening social inequities, regressive drug policy, widespread racism, fraying social safety net, toxic drug supply with >1,000 related deaths per year in one province

Challenges: GBV services underfunded and siloed from health; rising rates of GBV, widespread substance use stigma



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Equipping the GBV Sector for Substance Use Health

Ending Violence Association of BC
KSACC Kamloops Sexual Assault Counselling Centre
UBC
West Coast Community Resources Society

Co-Design in British Columbia

- Oct 2024: Community site selection
- Oct 2024-Oct 2025: Input on priorities and co-design of resources
- Mar-Sep 2025: Adapt resources to French

CAPSA

anova
CW Changing Ways
London Abused Women's Centre
Women's Rural Resource Centre
Muslim Resource Centre for Social Support and Integration
Western University · Canada
Huron Women's Shelter Second Stage Housing and Counselling Services
Building a Bigger Wave
Provincial Network for VAW Coordinating Committees

Co-Design in Ontario

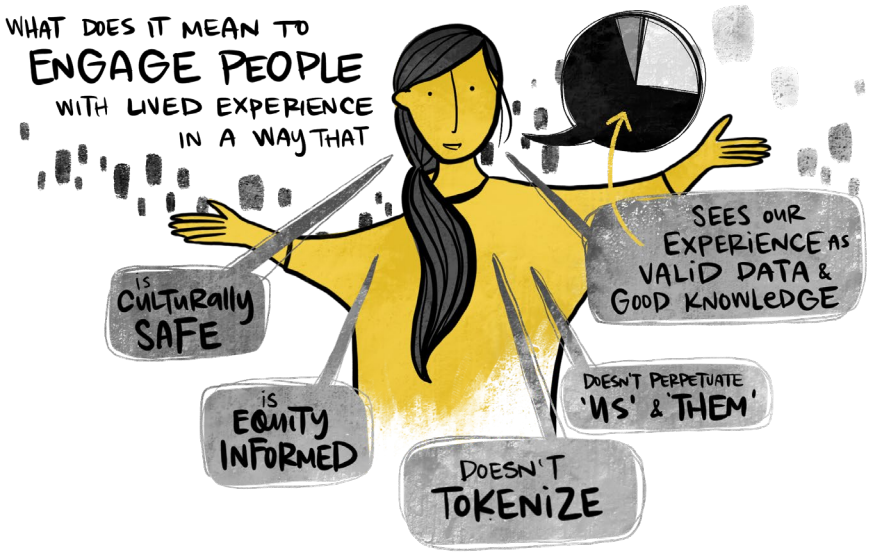
- 2024: Input on priorities and case studies
- 2025: Development of online course on GBV and Substance Use Health

UNB Est. 1785 University of New Brunswick

Co-Design in New Brunswick

- ~Jan 2026-Jan 2027: Trialing and adapting resources
- Adaptation to French

A Principles-Based Process of Co-Design



- ? Is your organization **interested** in strengthening your approaches to supporting people who use substances heavily?
- ? Is your organization **interested** in deepening coordination activities and relationships within your community that could support such approaches (e.g. substance use services)?
- ? Does your organization want to **play a role** in shaping these approaches across the gender-based violence and other sectors?
- ? Does your organization **have capacity** to partner on this project?
- ? Is your organization engaged or **poised** to further engage with people with lived experience of substance use stigma and gender-based violence?

Funding: $10,000 each for two sites

Animation

Imagine a woman—let's call her Anna. Anna has decided to get help after years of abuse from her partner. Lately, she's been using alcohol and opioids to help with the overwhelming pain and fear she feels. Anna thinks she needs to leave her partner to be safe, but she also knows there are risks that come with leaving.

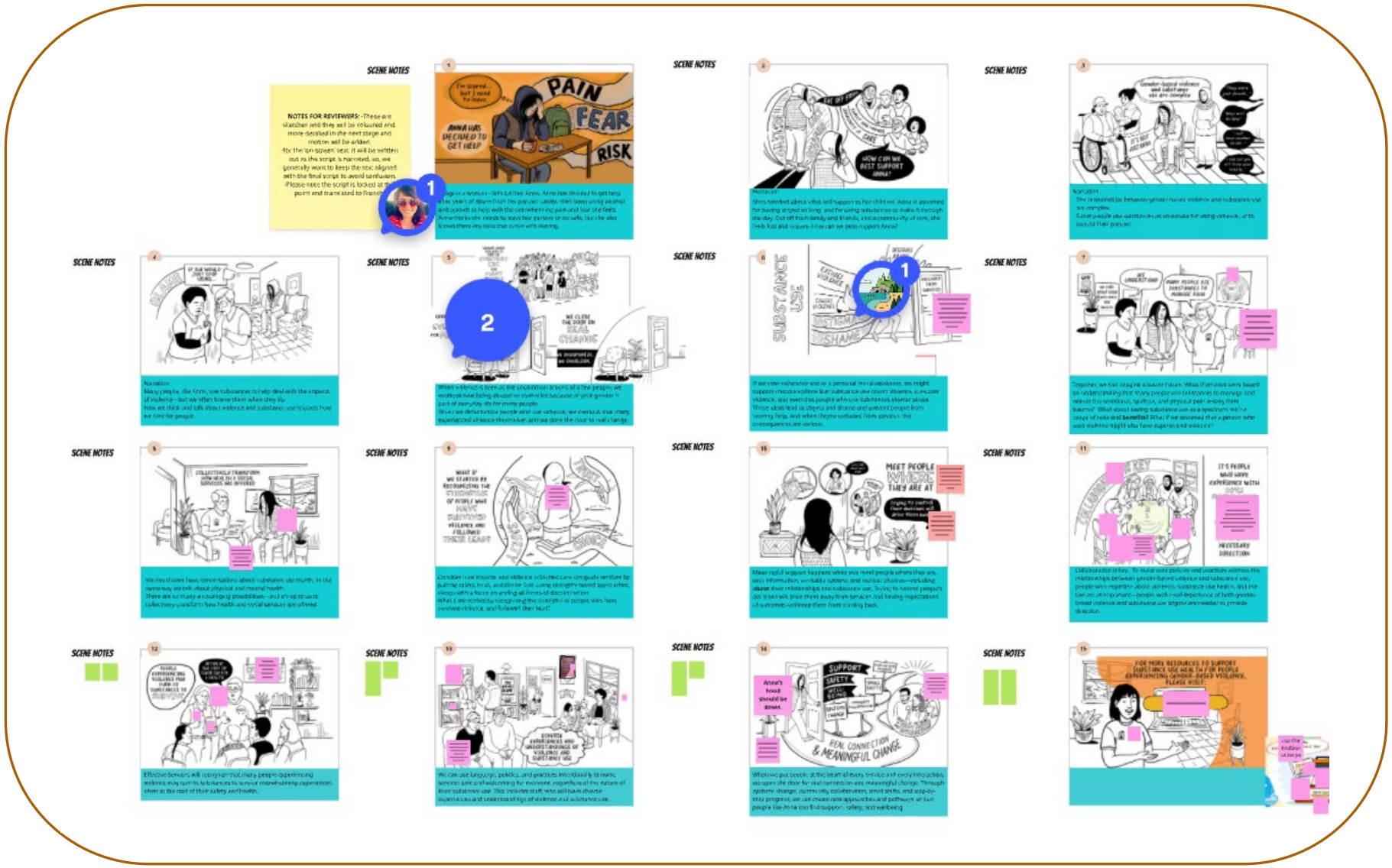
Narration

She's terrified about what will happen to her children. Anna is ashamed for having stayed so long, and for using substances to make it through the day. Cut off from family and friends, and a community of care, she feels lost and unsure. How can we best support Anna?

Design Through Co-Leadership

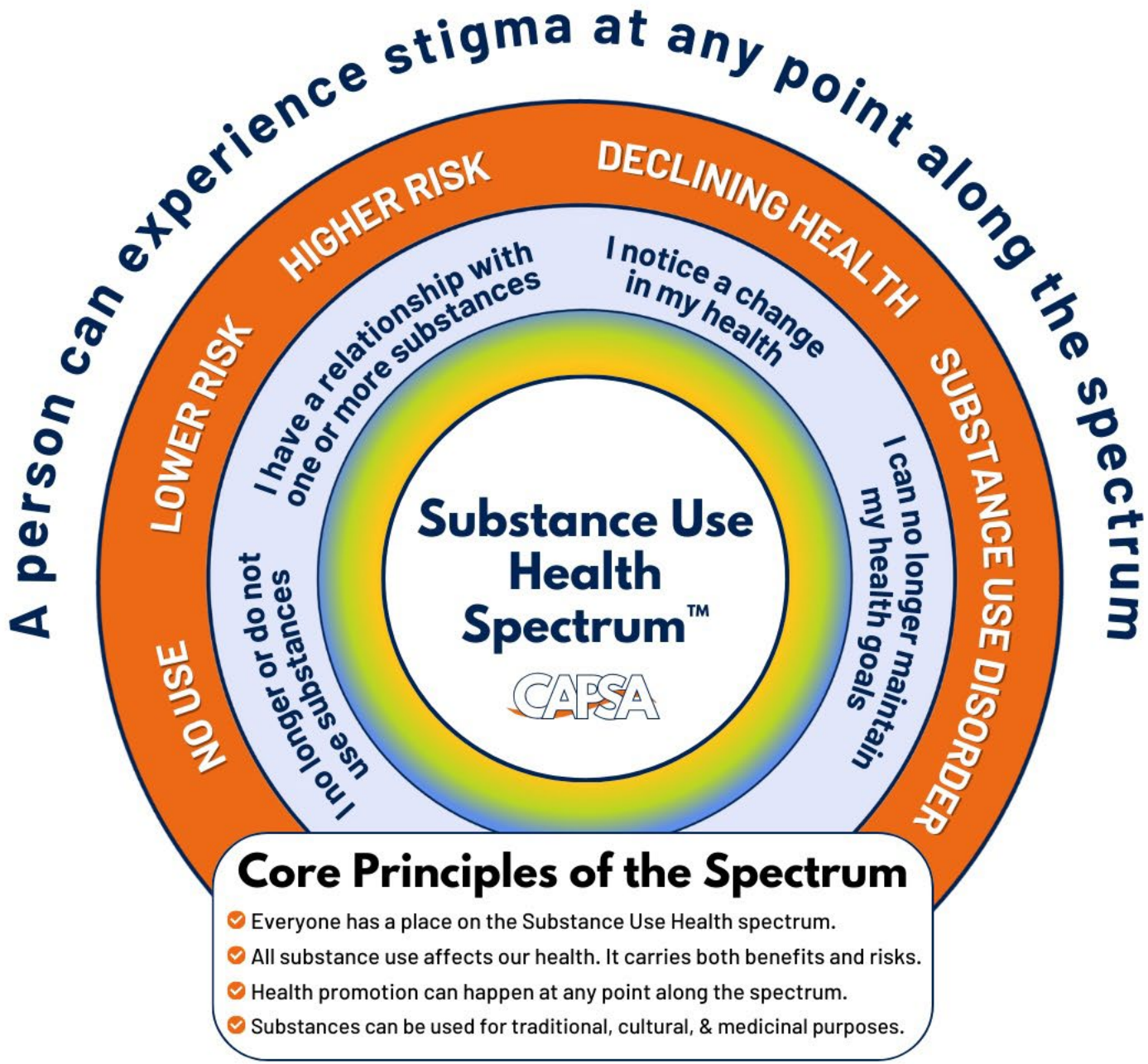
An iterative, relational approach to storytelling & design

- Building relationships and consensus
- Rewriting scripts collaboratively
- Providing line-by-line input
- Partnering and guiding at each stage
- Co-presenting learnings



Foundations

PLEASE FEEL FREE TO SHARE RELEVANCE TO PUBLIC HEALTH PRACTICE IN THE CHAT

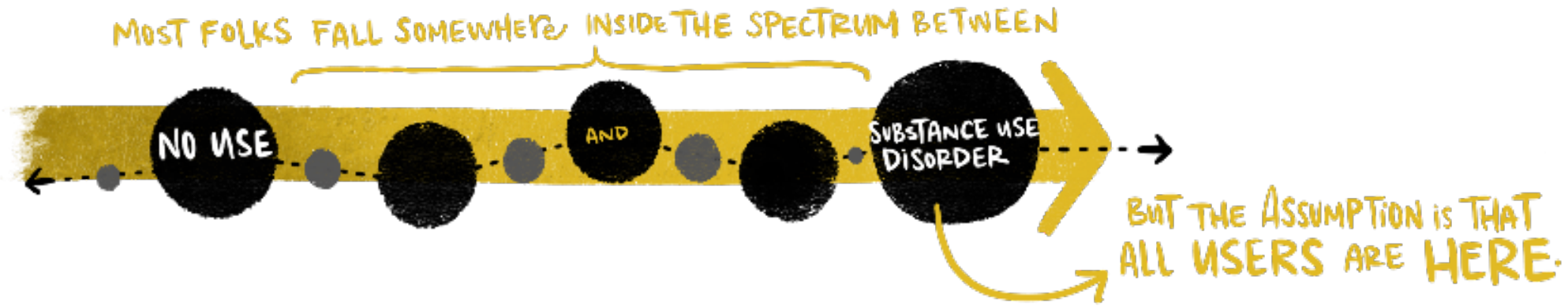


Core Principles of the Spectrum

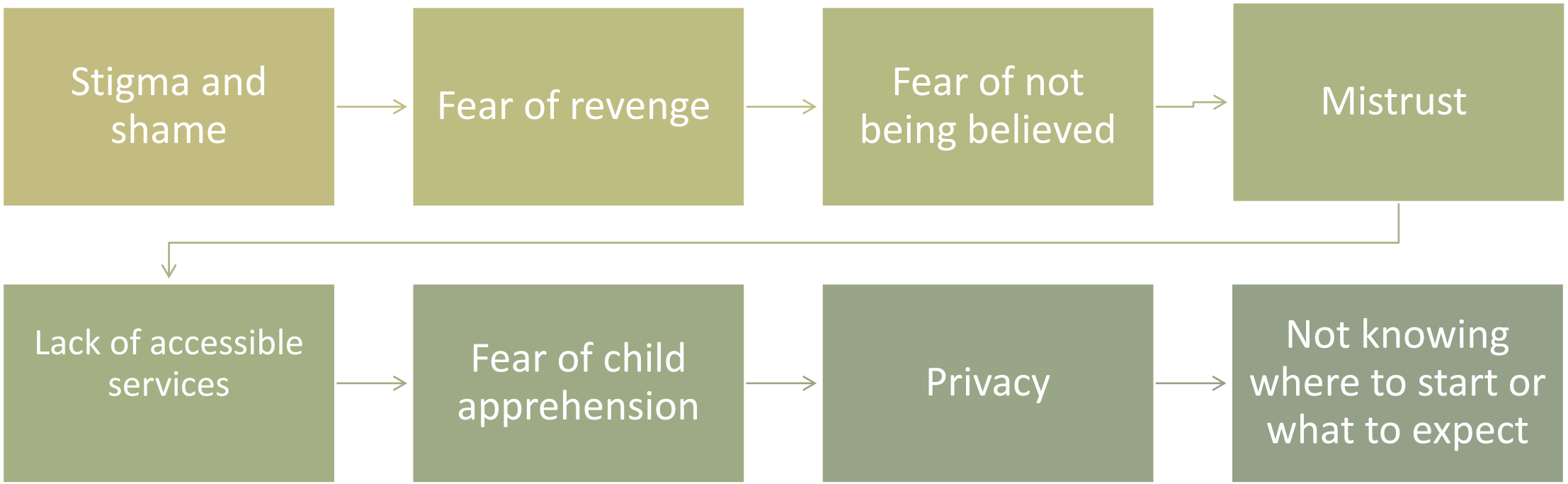
- Everyone has a place on the Substance Use Health spectrum.
- All substance use affects our health. It carries both benefits and risks.
- Health promotion can happen at any point along the spectrum.
- Substances can be used for traditional, cultural, & medicinal purposes.

EQUIP's uptake of Substance Use Health

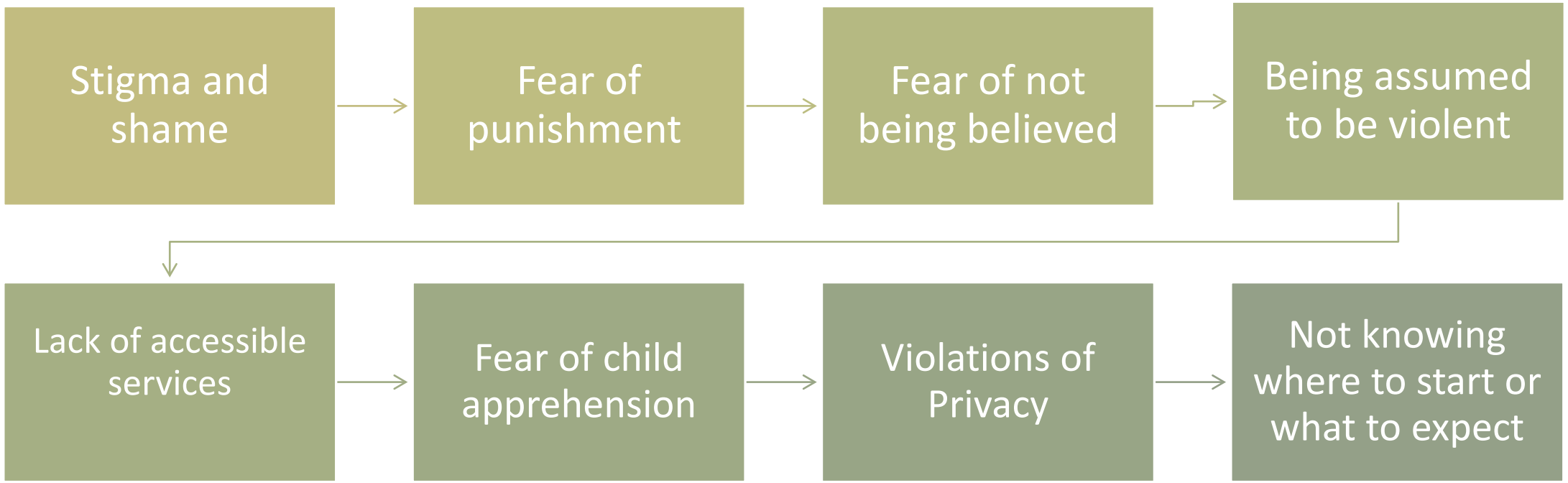
- Not "abstinence only"
- Focus on the spectrum of health effects, not 'addiction' and not just those with a diagnosis of "substance use disorder"
- Attends to systemic conditions and lack of choice
- Focuses on substance use as **learned**, not disease, not moral failing
- 'nothing about us without us' (with gratitude to the disability movement)



Barriers to Support for Women Experiencing IPV



Barriers to support for people using or assumed to be using substances in ways that harm health



Substance use-specific considerations

- Substance use does not **cause** violence
- Substance use does not **excuse** violence
- Substance use can be part of the dynamics of an abusive relationship in diverse ways (e.g., forced to use, prevented from using, being trafficked for substances)
- Each substance is stigmatized differently, and people are stigmatized differently depending on their social positions and privileges (e.g., income, education, perceived ethnicity)

The Intersecting Risks of Violence and HIV for Rural Aboriginal Women in a Neo-Colonial Canadian Context

Colleen Varcoe, RN, PhD, Associate Professor, School of Nursing, University of British Columbia

Sheila Dick, BEd, Counsellor/Family Support Worker, Canim Lake Band, Tsq'escenemc Nation

ABSTRACT

An ethnographic study looking at the intersecting risks of violence and human immunodeficiency virus (HIV) for rural women shows that the neo-colonial and racist context of Canadian society creates particular challenges for Aboriginal women. This article focuses on the experiences of the Aboriginal women who took part in the study. These women's experiences of violence occurred within a rural context of poverty and declining economic resources, and within a historical context of colonial abuses and cultural disruptions. Consequently, the women's lives were often characterized by disconnection from family and community, making them vulnerable to further violence and exploitation. Social support programs in this rural setting were limited and access was sometimes problematic. Understanding how the intersecting dynamics of gender, rural living, poverty, racism, and colonialism create risk for Aboriginal women provides a basis for developing policies that aim to strengthen the well-being of women, particularly their economic well being. It also highlights the need for an anti-racist agenda within the social service and health care sectors and at all levels of government.

KEYWORDS

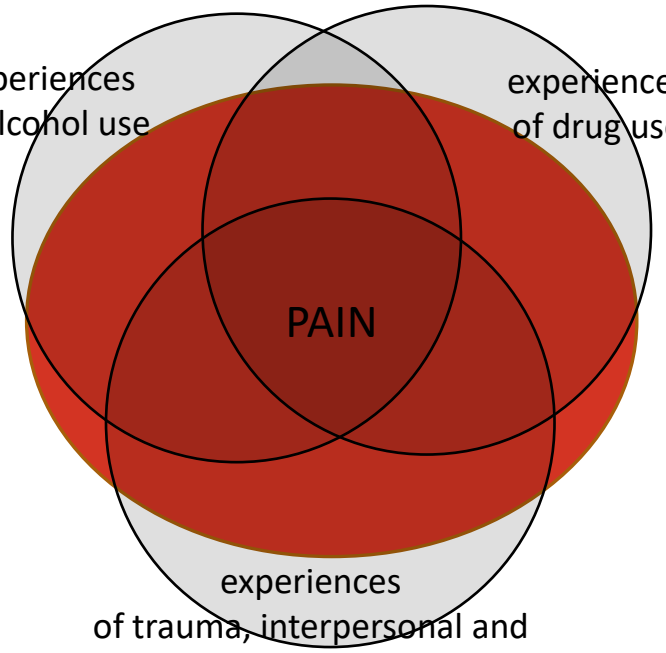
Violence against women, HIV, rural health, colonialism, gender, rural living, poverty, racism, Aboriginal women

INTRODUCTION

Because Aboriginal women face more structural inequities, they are at greater risk of both experiencing violence (Amnesty International Canada, 2004; Brownridge, 2003; Statistics Canada, 2005) and contracting human immunodeficiency virus (HIV) (Craib et al., 2003; Public Health Agency of Canada, 2006) than the general Canadian population. For instance, Aboriginal women aged 25–44 are five times more likely to die of violence than other Canadian women (Amnesty as compared to 16 per cent for non-Aboriginal women (Desmeules et al., 2003). Rural women face particular challenges related to poverty (Ross, Scott & Smith, 2000; Sutherns, McPhedran & Haworth-Brockman, 2004) and intimate partner violence (Biesenthal, Sproule & Plocica, 1997; Levett & Johnson, 1997) due to their isolation and because of limited economic opportunities and services in rural locales. Thus, Aboriginal women living in rural areas face multiple and intersecting forms of oppression. However,

***CHRONIC PAIN** may lead to self-medication in the face of stigma and inadequate pain care*

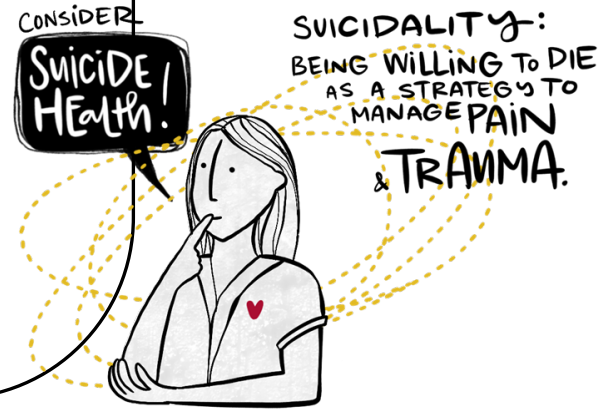
***CHRONIC PAIN** is stigmatized and intersects with stigma related to substance use, mental health and racism*



CHRONIC PAIN** is judged "legitimate" in ways that exclude **psychological pain

*Access to care for **CHRONIC PAIN** is impeded by structural inequities*

***CHRONIC PAIN** is a common outcome of experiences of trauma and violence*



Pain is often at the center of the intersections among trauma, violence, substance use and stigma

Bring substance use health into TVIC

PRINCIPLE	KEY SUBSTANCE USE CONSIDERATIONS
1. Understand trauma, violence and it's impacts on people's lives and behaviour	• Base organizational and individual approaches on understanding how substance use can be a tool of abuse, a excuse for violence, a strategy for managing pain…
2. Create emotionally and physically safe environments for all clients and providers	• Develop policies and approaches to enable service provision to people at all levels of substance use; extend non-judgemental unconditional positive regard to all
3. Foster opportunities for choice, collaboration and connection	• Identify and support client goals related to substance use health; Lobby for increased availability of VOLUNTARY treatment
4. Use a strengths-based and capacity building approach to support clients	• Recognize and acknowledge the challenges of the intersections among trauma, violence, pain, substance use and stigma

Resources

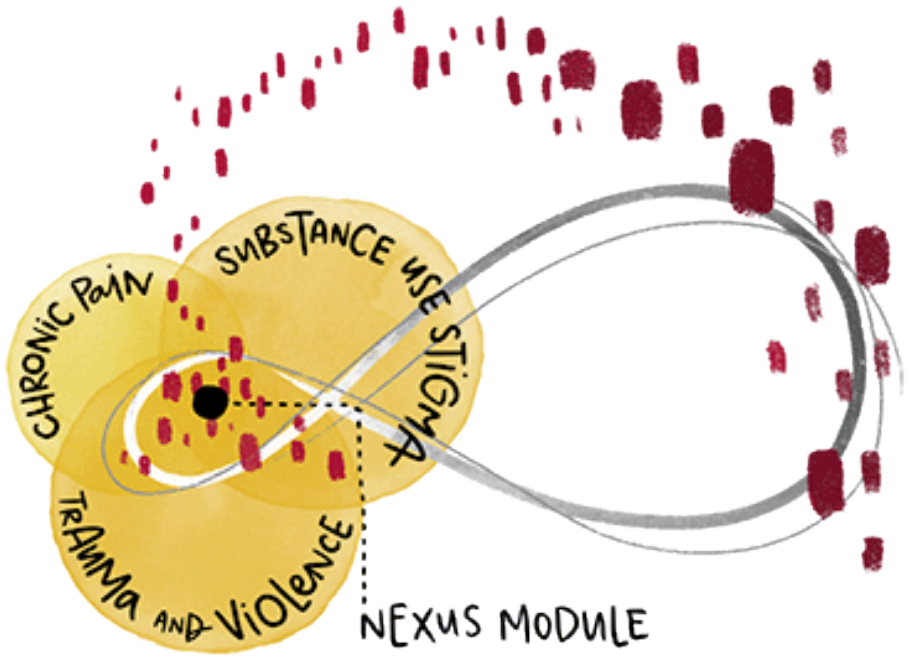
The Nexus Module:

https://equiphealthcare.ca/online-courses/nexus-module/

Invites health care and social service providers to:

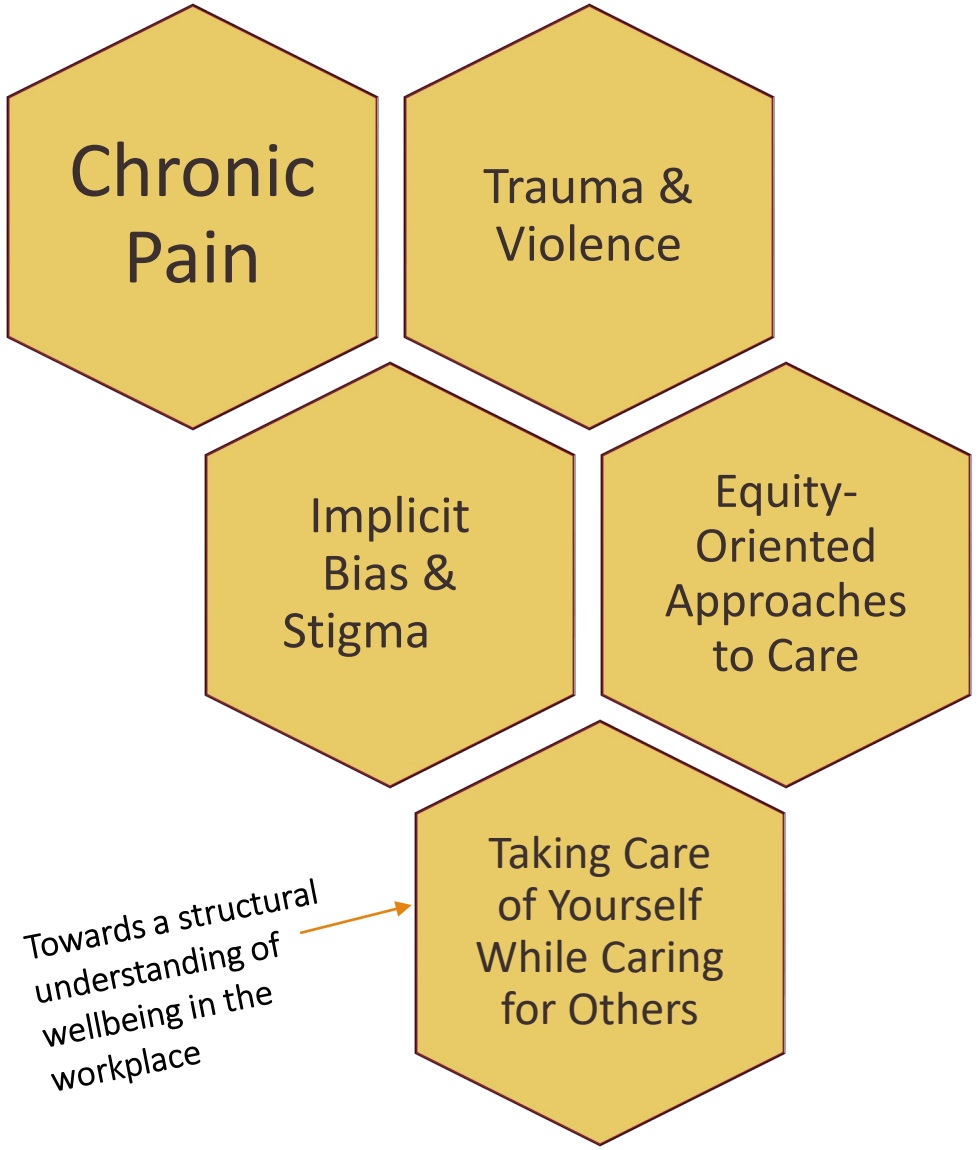
•consider the intersections of trauma, violence, substance use stigma, and chronic pain;
•reflect on their assumptions and potential for biases;
•consider the perspectives of people experiencing both substance use stigma and pain; and
•bring a structural lens to understanding wellbeing in the workplace

The Nexus Module has 7 sections, with **embedded videos, case-based activities, interactive quizzes**, and links to further resources throughout. After completing unit 7, successfully completing a brief quiz will provide a **Certificate of Completion.**



Research shows pain is poorly recognized, underestimated, undermanaged, and stigmatized.

Nexus: Course Content



Features

- Reflective activities
- Videos with experts
- Case studies
- Learning simulation
- Certificate of completion
- 10 hours to complete

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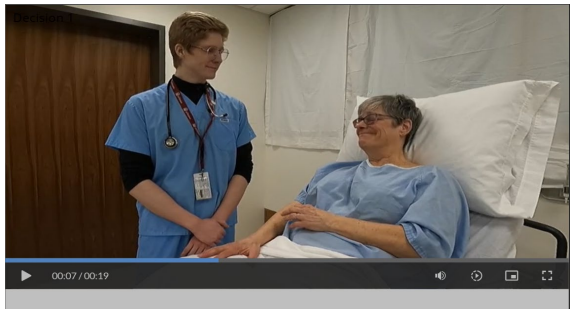
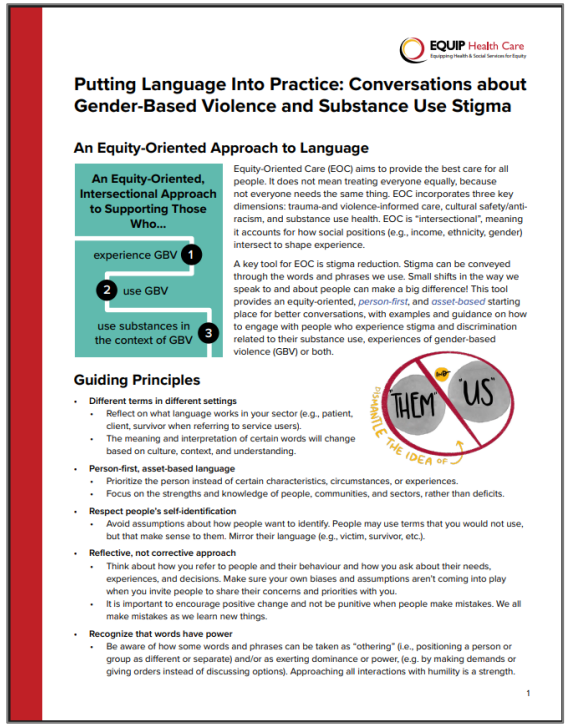


Pain is PERSONAL, COMPLEX and most of all, REAL.

Course Snapshot

Putting Language Into Practice: Conversations about Gender-Based Violence and Substance Use Stigma



EQUIP Health Care

Putting Language Into Practice: Conversations about Gender-Based Violence and Substance Use Stigma

An Equity-Oriented Approach to Language

An Equity-Oriented, Intersectional Approach to Supporting Those Who...

1. experience GBV
2. use GBV
3. use substances in the context of GBV

Equity-Oriented Care (EOC) aims to provide the best care for all people. It does not mean treating everyone equally, because not everyone needs the same thing. EOC incorporates three key dimensions: trauma-and violence-informed care, cultural safety/anti-racism, and substance use health. EOC is "intersectional", meaning it accounts for how social positions (e.g., income, ethnicity, gender) intersect to shape experience.

A key tool for EOC is stigma reduction. Stigma can be conveyed through the words and phrases we use. Small shifts in the way we speak to and about people can make a big difference! This tool provides an equity-oriented, *person-first*, and *asset-based* starting place for better conversations, with examples and guidance on how to engage with people who experience stigma and discrimination related to their substance use, experiences of gender-based violence (GBV) or both.

Guiding Principles

- **Different terms in different settings**
  - Reflect on what language works in your sector (e.g., patient, client, survivor when referring to service users).
  - The meaning and interpretation of certain words will change based on culture, context, and understanding.
- **Person-first, asset-based language**
  - Prioritize the person instead of certain characteristics, circumstances, or experiences.
  - Focus on the strengths and knowledge of people, communities, and sectors, rather than deficits.
- **Respect people's self-identification**
  - Avoid assumptions about how people want to identify. People may use terms that you would not use, but that make sense to them. Mirror their language (e.g., victim, survivor, etc.).
- **Reflective, not corrective approach**
  - Think about how you refer to people and their behaviour and how you ask about their needs, experiences, and decisions. Make sure your own biases and assumptions aren't coming into play when you invite people to share their concerns and priorities with you.
  - It is important to encourage positive change and not be punitive when people make mistakes. We all make mistakes as we learn new things.
- **Recognize that words have power**
  - Be aware of how some words and phrases can be taken as "othering" (i.e., positioning a person or group as different or separate) and/or as exerting dominance or power, (e.g. by making demands or giving orders instead of discussing options). Approaching all interactions with humility is a strength.

1

Language Matters

Substance Use Health (SUH) was developed by *CAPSA* and can be used in place of, or alongside the term Substance Use. SUH recognizes that substance use occurs on a spectrum and ranges from no use to various health risks and benefits, to use that can negatively impact a person's health and life. SUH is a strengths-based approach that focuses on supporting people's substance use health goals, including but not limited to managed use, reduced use, or abstinence. The following shows some examples of person-first, strength-based language:

AVOID THIS:	WHY?	TRY THIS:
"Problematic substance use," "addiction," "dependence," "habit," "abuse," or "misuse"	This framing is value-laden and reinforces stigma. Regular substance use is not inherently unhealthy.	"Substance use health concern," "self-identified heavy use," "heavy use over time," "regular substance use," "person who uses substances regularly," "substance use that harms health"
"Opioid crisis," "overdose crisis," or "accidental overdose"	The current crisis involves diverse substances, not only opioids. Harms include overdoses and deaths. The term overdose can blame individuals. Centering the toxic drug supply better recognizes the context in which substance use harms are occurring and the policies that drive it.[1]	"Toxic drug poisoning crisis," "drug toxicity crisis," "toxic drug overdose crisis," "substance use medical emergency"
"Junkie," "addict," "drug abuser," or "drug user"	These are stigmatizing labels that evoke inaccurate images of people who use substances as unstable and unworthy of support.[2]	Person first language such as "people/person" who use(s) substances" (as above); person with lived/living experience of substance use
"Dirty test results," "clean test results," or "clean and sober"	Avoid slang. Words such as "clean" and "dirty" evoke certain imagery that contributes to shame and stigma.	"Positive test results," "negative test results," "not using…," "reducing use of…"
"Drug seeking"	Assumes that people exaggerate or even invent pain to procure substances and is highly stigmatizing and dehumanizing.	"Presented for uncontrolled pain"
"Victim"	Focusing on the person and their strengths in the face of violence sets the stage for a strengths-based approach and is non-judgmental.	"Survivor"
"Perpetrator" or "abuser"	Move towards humanizing language for everyone, without removing accountability.	"Person who uses/used violence," "Person who causes/caused harm"
"Battered woman," "abused," or "at risk"	This language is deficit based and reduces a person to one aspect of their lived experience. Person-first language shifts focus onto people's experiences.	"Has a history of…," "living with…," "experiences of…," "has survived…"
"They don't want help," "non-compliant," "unmotivated," or "resistant client"	Reinforces stigma, blames individuals, and is deficit based. Person-first language shifts attention to how systems can better meet needs.	"Our help isn't meeting their needs," "care is unsuitable," "unable to adhere to/facing barriers"
"Refuses to leave partner"	Positions "leaving" as a condition for receiving care and assumes that the survivor wants to leave (versus, for example, wanting the violence to end) or can leave safely, even if they want to.	"Requires support/referral for safety planning"

2

Intersectional Considerations

Harmful assumptions about substance use and GBV experiences are often compounded by assumptions based on people's social positions.

DON'T ASSUME... that people choose to use substances.

Remember that: people use substances for a variety of reasons, including to help relieve pain and cope with experiences of trauma and systemic/structural violence. Reserve judgement and practice with compassion, humility, respect, and curiosity.

DON'T ASSUME... that people living in poverty or faced with homelessness are likely to be violent or use substances.

Remember that: people who don't have access to private transportation and private homes/spaces are more visible to the public, and their use of substances or violence may be more visible.

DON'T ASSUME... that someone's culture or religion determines their likelihood of using or experiencing violence.

Remember that: misogyny and patriarchy are at the roots of gender-based violence against women.

DON'T ASSUME... that because a person's culture or religion prohibits substance use that substance use will not occur.

Remember that: people from all backgrounds can experience substance use health concerns.

DON'T ASSUME... the high rates of violence against Indigenous women mean that Indigenous Peoples are generally more violent.

Remember that: such violence also is perpetrated by non-Indigenous people[3] and that violence against Indigenous women is a failure at every level of the system. Structural violence, especially colonialism and racism, have created conditions where Indigenous people are over-surveilled, over-represented in harmful systems like child welfare and correctional facilities, and are more likely to experience poverty, violence and pain due, for example, to barriers to education, employment and housing and intergenerational trauma from Residential Schools.

DON'T ASSUME... Indigenous people use substances more than the general population.

Remember that: many Indigenous people do not use alcohol or other drugs.[4,5] Data indicates that Indigenous people in BC consume less alcohol per capita than the general population[6] and that 35.3% of Indigenous adults abstained from alcohol in the last 12 months, compared to only 20.7% of Canadians who do not self-identify as Indigenous.[7]

[1]Canadian Drug Policy Coalition. (n.d.). History of drug policy in Canada. *https://drugpolicy.ca/about/history/*
[2]Note that many people who use substances might refer to themselves or others in these ways, but providers are encouraged to use the suggested person-first and non-stigmatizing terms, both in discussions with and about people, and in documentation.
[3]National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). Reclaiming power and place. The final report of the national inquiry into missing and murdered indigenous women and girls. The National Inquiry. *https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf*
[4]Sikorski, C., Leatherdale, S., & Cooke, M. (2019). Original quantitative research – Tobacco, alcohol and marijuana use among Indigenous youth attending off-reserve schools in Canada: cross-sectional results from the Canadian Student Tobacco, Alcohol and Drugs Survey. Health Promotion and Chronic Disease Prevention in Canada, 39 *https://doi.org/10.24095/hpcdp.39.6/7.01*
[5]Statistics Canada. (2014). A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 2006 to 2010. *https://publications.gc.ca/collections/collection_2014/sc-hc/H34-193-1-2014-eng.pdf*
[6]British Columbia Provincial Health Officer. Report on the health of British Columbians. Provincial health officer's annual report 2001. The health and well-being of Aboriginal people in British Columbia. 2002, Victoria, BC. Available from: *http://www.health.gov.bc.ca/pho/reports/*
[7]The First Nations Information Governance Centre. First Nations Regional Health Survey (RHS) Phase 2 (2008/10): National report for adults, youth and children living in First Nations communities. Key Finding from the National Report. 2012, Ottawa, Ontario. Available from: *http://fnigc.ca/sites/default/files/RHS_Phase_II_-_Key_Findings.pdf*

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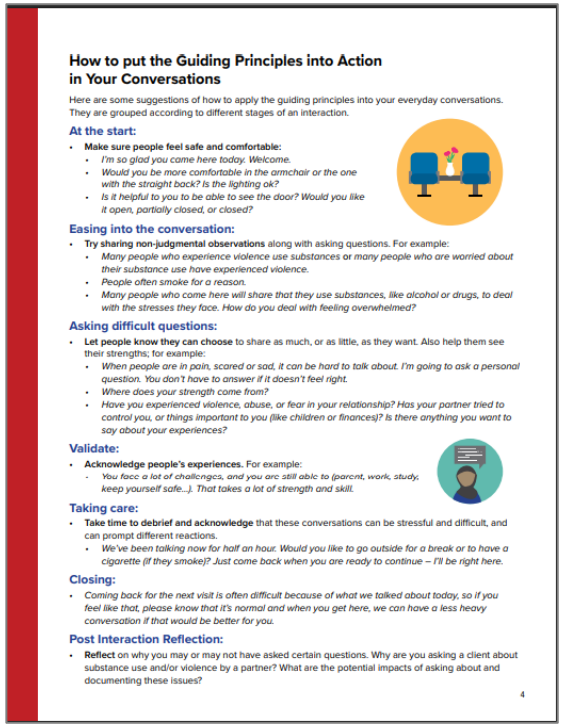


How to put the Guiding Principles into Action in Your Conversations

Here are some suggestions of how to apply the guiding principles into your everyday conversations. They are grouped according to different stages of an interaction.

At the start:

- **Make sure people feel safe and comfortable:**
  - *I'm so glad you came here today. Welcome.*
  - *Would you be more comfortable in the armchair or the one with the straight back? Is the lighting ok?*
  - *Is it helpful to you to be able to see the door? Would you like it open, partially closed, or closed?*

Easing into the conversation:

- **Try sharing non-judgmental observations** along with asking questions. For example:
  - *Many people who experience violence use substances or many people who are worried about their substance use have experienced violence.*
  - *People often smoke for a reason.*
  - *Many people who come here will share that they use substances, like alcohol or drugs, to deal with the stresses they face. How do you deal with feeling overwhelmed?*

Asking difficult questions:

- **Let people know they can choose** to share as much, or as little, as they want. Also help them see their strengths; for example:
  - *When people are in pain, scared or sad, it can be hard to talk about. I'm going to ask a personal question. You don't have to answer if it doesn't feel right.*
  - *Where does your strength come from?*
  - *Have you experienced violence, abuse, or fear in your relationship? Has your partner tried to control you, or things important to you (like children or finances)? Is there anything you want to say about your experiences?*

Validate:

- **Acknowledge people's experiences.** For example:
  - *You face a lot of challenges, and you are still able to (parent, work, study, keep yourself safe…). That takes a lot of strength and skill.*

Taking care:

- **Take time to debrief and acknowledge** that these conversations can be stressful and difficult, and can prompt different reactions.
  - *We've been talking now for half an hour. Would you like to go outside for a break or to have a cigarette (if they smoke)? Just come back when you are ready to continue – I'll be right here.*

Closing:

- *Coming back for the next visit is often difficult because of what we talked about today, so if you feel like that, please know that it's normal and when you get here, we can have a less heavy conversation if that would be better for you.*

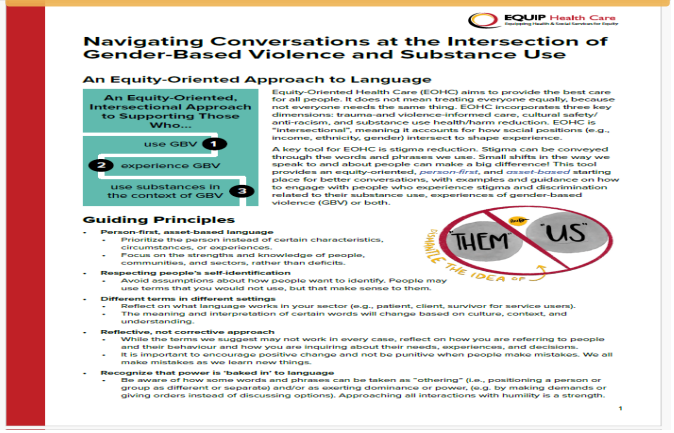
Post Interaction Reflection:

- **Reflect** on why you may or may not have asked certain questions. Why are you asking a client about substance use and/or violence by a partner? What are the potential impacts of asking about and documenting these issues?

4

More to come - Visit www.equiphealthcare.ca

Print Resources


EQUIP Health Care

Navigating Conversations at the Intersection of Gender-Based Violence and Substance Use

An Equity-Oriented Approach to Language

An Equity-Oriented, Intersectional Approach to Supporting Those Who...

use GBV 1

2 experience GBV

use substances in the context of GBV 3

Equity-Oriented Health Care (EOHC) aims to provide the best care for all people. It does not mean treating everyone equally, because not everyone needs the same thing. EOHC incorporates three key dimensions: trauma-and violence-informed care, cultural safety/ anti-racism, and substance use health/harm reduction. EOHC is "intersectional", meaning it accounts for how social positions (e.g., income, ethnicity, gender) intersect to shape experience.

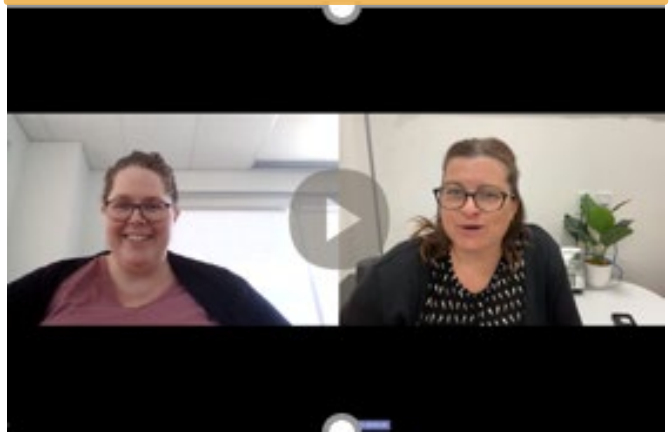
A key tool for EOHC is stigma reduction. Stigma can be conveyed through the words and phrases we use. Small shifts in the way we speak to and about people can make a big difference! This tool provides an equity-oriented, *person-first*, and *asset-based* starting place for better conversations, with examples and guidance on how to engage with people who experience stigma and discrimination related to their substance use, experiences of gender-based violence (GBV) or both.

Guiding Principles

- Person-first, asset-based language
  - Prioritize the person instead of certain characteristics, circumstances, or experiences.
  - Focus on the strengths and knowledge of people, communities, and sectors, rather than deficits.
- Respecting people's self-identification
  - Avoid assumptions about how people want to identify. People may use terms that you would not use, but that make sense to them.
- Different terms in different settings
  - Reflect on what language works in your sector (e.g., patient, client, survivor for service users).
  - The meaning and interpretation of certain words will change based on culture, context, and understanding.
- Reflective, not corrective approach
  - While the terms we suggest may not work in every case, reflect on how you are referring to people and their behaviour and how you are inquiring about their needs, experiences, and decisions.
  - It is important to encourage positive change and not be punitive when people make mistakes. We all make mistakes as we learn new things.
- Recognize that power is 'baked in' to language
  - Be aware of how some words and phrases can be taken as "othering" (i.e., positioning a person or group as different or separate) and/or as exerting dominance or power, (e.g. by making demands or giving orders instead of discussing options). Approaching all interactions with humility is a strength.

THEM "US"

Podcast Series



Game-Based Learning

Animated Videos

Online Course

Action Kit

Thank you!

Questions, Comments?

FOR MORE RESOURCES TO SUPPORT SUBSTANCE USE HEALTH FOR PEOPLE EXPERIENCING GENDER-BASED VIOLENCE, PLEASE VISIT: