Community Mobilization for Women and Girls Who Self-Harm:
An Environmental Scan of Manitoba Service Providers

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REPORT SUMMARY

Self-harm among women and girls is a serious health concern in Canada (Fillmore and Dell, 2001; Presse and Hart, 1999; Arbour, 1996; CAEFS, 1995; Weekes and Morrison, 1992). In 2000, the Elizabeth Fry Society of Manitoba initiated an *exploratory study* of women in correctional institutions and in the community who had a history of self-harm. Considerable understanding and insight was gained from this research regarding the women's perceptions of self-harm, their needs, the risk factors, and the programs (supports and services) provided by community agencies and correctional institutions to address self-harm. Greater awareness was also attained in these areas regarding staff perceptions of self-harm and the centrality of culture in Aboriginal healing programs, supports and services. The full report, *Prairie Women, Violence and Self-Harm* (PWVSH), can be accessed at: http://www.pwhce.ca/pdf/self-harm.pdf. Some of the major findings of this study included the following:

- There was a strong relationship between childhood and adult experiences of violence and involvement in self-harm;
- The onset of self-harm occurred primarily in adolescence;
- There was a lack of awareness of existing resources for self-harm in the community and in correctional institutions;
- Specific programs and clear guidelines and policies on self-harm were generally lacking in both community and correctional settings;
- There was a critical need for Aboriginal programs, supports and services designed and delivered by Aboriginal women.

Informed by the women's narratives, staff perceptions, and a review of the inter-disciplinary literature, a definition of self-harm evolved in the research as follows:

> Any behaviour, be it physical, emotional, social or spiritual, that a woman commits with the intention to cause herself harm. It is a way of coping and surviving emotional pain and distress, which is rooted in traumatic childhood and adult experiences of abuse and violence. It is a meaningful action, which fulfils a variety of functions for women in their struggle for survival.

A corresponding Holistic Model of Self-Harm was also constructed. It demonstrated the wide range of conduct that involved the body in the expression of emotional pain and distress. This ranged from inflicting external forms of harm, e.g., slashing the skin, to less visible, internal forms of harm, e.g., substance abuse. There were six main categories of self-harm classified in this model. In hierarchical order, these were: 1. physical self-injury; 2. self-destructive behaviours; 3. destructive relationships; 4. expressions of suicide; 5. body enhancement, and 6. self-injury related to psychiatric disorders. The nature of women's self-harm was clearly multi-dimensional and complex. Many of the women had become disenfranchised through poverty, sexism, a history of colonization, racism and discrimination, and it was within this context that some women turned to self-harm. *This understanding led to a view of self-harm as a necessary though unhealthy way of coping with distressing and oppressive conditions in women's lives.* This perspective on self-harm became the foundation of the subsequent two phases of the self-harm project.

In 2002, the Elizabeth Fry Society developed a *second phase* of the self-harm project. The focus of this project was to increase awareness of self-harm as an important health issue among criminalized women through a systematic dissemination of the research findings from the 2001 report, *Prairie Women, Violence and Self-Harm,* as well as to strategically disseminate this new knowledge. The major target populations were foremost the women participants of the study, women in the community and correctional institutions who self-harm, service providers, major decision makers in the fields of health and justice, and educators in the school and university systems.

In 2003, the Elizabeth Fry Society established *phase three* of the self-harm project. Both the findings of the 2001 PWVSH study and the team's knowledge translation activities signalled the need to gain a greater understanding of the perspective of community service providers on women's and adolescent girls' self-harm. In this phase, the research team worked in active collaboration with the Winnipeg Intersectoral Committee on Self-Harm, which was established during the second phase of the project, to develop an environmental scan of Manitoba community and institutional service providers who work with women and girls who self-harm.

The purpose of this current environmental scan is to examine the knowledge, experiences and practices of service providers on several dimensions of self-harm: social portraits of women and girls who self-harm; definitions, perceptions and awareness of self-harm; prevalence of self-harm; risk factors; responses to self-harm; and recommendations. The major research goals are to build a knowledge-base of the perceptions and awareness of self-harm across a broad spectrum of community and institutional service providers in Manitoba, to construct a database of existing resources, to identify guidelines for programs and policies, to investigate specific research questions and relationships that emerged from the 2001 PWVSH research, and to share this information in a Manitoba community forum and to plan the next steps for action in developing guidelines for self-harm programs and policies.

Survey Respondents—the Service Providers

The client population of the service providers was based on three main groups. The largest client group was composed of women and girls, followed closely by women clientele, and then a client group of adolescent girls only. Nearly half of the agencies provided services specific to Aboriginal women and/or adolescent girls. The majority of the service providers occupied managerial and supervisory positions, and roughly one-third of them were in front-line staff positions. Most of the respondents had been in their current position for several years. The average length of employment for supervisors was close to 10 years, and for both managers and front-line staff, it was just over seven years. The respondents had considerable work experience in their field, with supervisors averaging just over 16 years of experience, and front-line staff and managers averaging around 12 and 14 years, respectively.

Social Portrait of Women and Girls Who Self-Harm

The service providers' social portrait of their *adult women* clientele who self-harm reflected to a large degree the women in the 2001 PWVSH study. The majority of the women clients were in their early and middle adult years. They had relatively low levels of educational attainment, although nearly one-fifth of them had obtained some level of post-secondary education. Thirty-nine percent of the women had completed junior high, and 26% of them had finished high school. Nearly half of the women were Aboriginal and about one-third were Caucasian. The women had high rates of unemployment and underemployment. More than two-thirds of the women were unemployed, and only 16% of them were able to secure full-time work. Only a third of the women were married or living common-law. A third of the women were single, while another third separated, divorced or widowed. It is important to note that over three-quarters of the women had dependent children to support. Two-thirds of the women were Canadian citizens. Among the agencies that worked with adult women, approximately half of their clientele had a history of criminalization. Like the 2001 PWVSH study, this portrait underlined the material deprivations of poverty and the women's difficulties in accessing stable employment to support themselves and their children.

The service providers reported that their women clients had experienced significant levels of abuse and violence in their lives both during their childhood and as adults. They had a history of child abuse from family members as well as from strangers. In their adult years, they experienced considerable partner violence. Of special significance is the finding that abuse by a former partner was the most common type of abuse experienced by the women. This was supported in the 2001 PWVSH study, which also found a strong relationship between partner abuse and violence and self-harm. The service providers also reported that their women clientele were perpetrators of physical aggression or violence throughout their childhood and adult lives. The most common context for its expression was within the family. This was another finding that was strongly supported in the 2001 PWVSH study. Finally, for a large majority of women, a pattern of physical aggression or violence originated in their adolescence.

The 2001 PWVSH study did not address *adolescent girls* specifically, but the findings suggested that the onset of self-harm was typically in adolescence. For the current

environmental scan, the service providers described several traits of their adolescent client population. Approximately half of the adolescent girls were between 12 and 14 years old, and half were between 15 and 17. With respect to schooling, 46% of the adolescent girls were attending junior high, and a third of them were attending high school. Of special note is that a sizable percentage (18%) of the girls were not attending school. Approximately a third of the girls worked, although these were mostly in part-time jobs. A large percentage (63%) of the adolescent girls were Aboriginal, and about a quarter of them were identified as Caucasian. Slightly more than two-thirds of the girls were Canadian citizens. Among the agencies that reported working with adolescent girls, two-fifths of their clientele had a history of criminalization.

A striking feature of the service providers' social portrait of the adolescent girls was the high level of family disruption and trauma in their lives. Only 36% of the girls lived with their families, while the rest lived in foster families, residential facilities or group homes. A small percentage (8%) of the girls lived on the streets or with their friends. Another significant feature was the high degree of family abuse and violence experienced by the adolescent girls, even greater than that reported for the adult clientele. Like the women clientele, the adolescent girls also experienced considerable abuse and violence both from strangers and in their dating relationships. Finally, in keeping with the findings for the women clientele, the service providers reported that the adolescent girls had also displayed physical aggression, and that it was primarily against other family members.

Definitions, Perceptions and Awareness of Self-Harm

Nearly a half of the service providers reported that their agency had formulated a *definition* of self-harm. These definitions shared three main themes: 1. self-harm involves a broad range of behaviours; 2. it is a coping or survival response to deep emotional pain; and 3. it is an intentional act without conscious suicidal intent. This perception of self-harm is highly consistent with the findings of the 2001 PWVSH study.

The service providers generally were in strong agreement with all of the *types of self-harm* listed in the survey. These were identical to those listed in the 2001 PWVSH study, and this finding corroborated the view that self-harm involves a diverse range of behaviours. There was also a similar ranking in terms of the importance of each type of self-harm, with physical self-injuries, sexual risk-taking and substance abuse ranked at the top. It is important to point out that the service providers identified a few new forms of self-harm, for example, gambling and gang affiliation.

All the service providers agreed with the view of self-harm as a coping strategy to deal with emotional pain and distress. They also supported all of the *coping functions* of self-harm that were listed in the survey, which were consistent with those in the 2001 PWVSH study. There were, however, some significant new findings. The service providers in the present study showed much greater awareness of self-harm as a response to an abusive partner, as a form of cleansing or releasing of emotional pain, and as a means of regaining power or control over one's self.

More than 60% of the service providers reported that their agency did not have a policy on self-harm. The lack of a clear policy on self-harm was a consistent finding with the 2001 PWVSH research. For the service providers who reported a policy on self-harm in the present study, a fairly common response in community settings was a harm-reduction and protection planning model. In institutional settings, some service providers described their use of "behaviour chain analysis," a practice that involved charting incidents and possible triggers as well as close monitoring or constant observation following an incident of self-harm. Some service providers reported the protocol of a specific suicide risk assessment tool and an intervention strategy, while others emphasized that incidents of self-harm needed to be treated differently than suicidal behaviour. The responses of service providers, working in crisis or urgent care centres, differed in some respects by emphasizing the importance of client involvement—for example, the women treating their own wounds; and they also indicated a concern with "copycat" behaviour. Specific to the adolescent age group, service providers noted that contacting guardians and assisting with making agency referrals were a common part of their policy responses. A third of the service providers who did not have a direct policy on self-harm identified alternative health care policies that fell under various types of legislation, such as the Mental Health Act and Child Protection Act, as well as emergency department protocol. An important finding that emerged was the recognized need for an integrated and systemic approach to self-harm policies.

The findings from the 2001 PWVSH study suggested that clients for the most part can make a clear distinction between self-harm and *suicidal behaviours*. Based on their professional experiences and opinions, the service providers in the present study also indicated that most clients were able to make a distinction between self-harm and suicidal intentions. This view, however, was not shared by all service providers. While the majority of service providers felt that their clients were able to make a clear distinction, they also expressed some doubt for a small number of their clients. Furthermore, some of the service providers' responses indicated that they wanted a clearer understanding of the relationship and differences between self-harm and suicide. This is an area of unquestionable concern to service providers, and one that requires further study and careful examination.

In the 2001 PWVSH study, the correctional staff identified *peer influence* as a risk factor for women's involvement in self-harm in a residential setting. For the service providers in this environmental scan, however, there was considerable uncertainty about the role of peer influence for women and adolescent girls. Seventy-five percent of the service providers for adolescent girls and 44% of the service providers for women expressed uncertainty regarding the role of peer influence on self-harm. Similar percentages of service providers felt that peer influence was a factor in women's and adolescent girls' self-harm—22% and 17% respectively. The open-ended responses by the service providers provided greater insight into this relationship, suggesting that adolescent peers who self-harm were a contributing factor to girls' involvement in self-harming behaviours. This is another area that requires further investigation.

Prevalence of Self-Harm

The service providers found it difficult to estimate the prevalence of self-harm among their adult and adolescent female clientele. Two-thirds of the service providers, for example, were unable to provide any information on the extent of self-harm and on any changes in the rates of self-harm for their clientele over the past two years. For those respondents who identified an increase in self-harm among women and adolescent girls in community agencies and correctional institutions, certain similarities were found both in the forms of self-harm (physical self-injurious behaviours, alcohol and drug abuse, and destructive relationships) and in the reasons for the increase in self-harm (family problems, past abuse, greater service provider awareness, and an increased comfort in disclosure). A number of factors appeared to influence the prevalence rates and should be considered in reviewing these findings. These factors related to the reasons for low reporting rates (e.g., respondents' fear of a punitive response) as well as for high reporting rates (e.g., increased awareness of self-harm among service providers). There are other factors that should also be taken into account, such as variations in the definition of self-harm (from specific to general) and a lack of systematic data collection.

More specifically, 14% of the *community service providers* identified an increase in self-harm among their *women clients* for four types of self-harm: physical self-injurious behaviours (slashing, burning), alcohol and drug abuse, sexual risk taking, and involvement in destructive relationships. Some of the major reasons reported for this increase were related to family and marital problems, abuse issues and a greater openness of service providers in addressing self-harm.

For *correctional institutions*, 21% of the service providers reported an increase in *women's* self-harm, notably for three types of self-harm: physical self-injurious behaviours, alcohol and drug use, and tattooing. Gambling, a type of self-harm not identified in the 2001 PWVSH study for incarcerated women, was also reported. The main reasons identified for this increase in self-harm were associated with a greater awareness among correctional staff about self-harm as a coping response and a greater willingness among the women themselves to talk about their self-harming behaviours to staff.

With respect to *adolescent girls*, 21% of the *community service providers* identified an increase in self-harm—a higher percentage than that reported for the women clientele. They reported that the most common increases in self-harm were for physical self-injurious behaviours and destructive relationships. Consistent with the findings for the women clientele, the service providers identified family and relationship problems as the major reasons for the increase in self-harm among adolescent girls. In addition, they identified two other important factors: loss of cultural identity for Aboriginal girls and the influence of peers who self-harm. The service providers related this increase in self-harm to greater agency awareness and reporting of self-harm and to greater client disclosure.

For *correctional institutions*, 22% of the service providers identified an increase in *adolescent girls'* self-harm—a similar increase to that reported for women. The respondents reported increases mainly for physical self-injurious behaviours, drug and

alcohol abuse, and destructive peer relationships. The major reasons that the respondents identified for this increase were family abuse, placement breakdowns, loss of family connection and cultural identity issues for Aboriginal girls.

Risk Factors for Self-Harm

The painful experiences of marginalization and disenfranchisement that the women and adolescent girls endured in their daily lives strongly shaped their ability to cope. For many of the women and girls, these conditions increased their emotional pain and distress and therefore the propensity to self-harm. The service providers identified eight major areas that they felt placed *women* at risk of self-harm in the *community*. These included the following: experiences of abuse and violence, family disruption, social isolation, unhealthy personal relationships, poor levels of health, and social structural factors, primarily those related to subsistence living and consequent discrimination and marginalization. These findings are consistent with the risk factors reported for women in the 2001 PWVSH research. The service providers in this environmental scan, however, described these risk factors in much greater detail and also identified additional areas of risk. They detailed, for example, the devastating impact of residential schools and the history of colonization as factors that increased Aboriginal women's risk of self-harm. In addition, the respondents identified negative relationships with government agencies as a risk factor. Finally, the service providers emphasized community disorganization and lack of resources as important factors contributing to women's self-harm in the community.

The service providers identified six main risk factors for *women in institutions*. It is important to point out that the respondents focussed primarily on correctional facilities. These were separation from family, stressful conditions of the institutional environment, negative staff relations, difficult peer relationships, segregation and mental health issues. Three of the central risk factors that the service providers identified were directly related to the emotional distress experienced by women placed in detention, notably the pains of imprisonment. These factors were concerns and fears of losing their children, the trauma of segregation, and negative relationships with institutional staff. While the correctional staff in the 2001 PWVSH study did not report negative staff relations, the women in that study did identify this as a risk factor for self-harm. In both studies, the service providers placed great emphasis on the conditions of the institutional environment and its role in increasing women's emotional pain and distress and thus their tendency to self-harm.

In the 2001 PWVSH study, many of the women identified adolescence as the period for the onset of self-harm. The service providers in the present study identified six major risk factors for *adolescent girls* in the *community*. These were experiences of abuse and violence, family disruption and trauma, social isolation and lack of healthy peer relationships, weak ties and involvement in youth community activities and lack of access to resources, poor personal health factors, and social structural factors, mainly related to family poverty and transient living conditions. Although adolescent girls and women in the community shared certain risk factors, particularly experiences of abuse and violence, for adolescent girls there was an even greater concern with sexual exploitation by family members and/or strangers and involvement in the sex trade. Other

similarities included lack of community resources, social isolation, and personal health factors such as alcohol and drug abuse. Overall, the service providers identified a multiplicity of risk factors and emphasized the confounding effects of poverty, abuse, poor mental health, developmental disabilities, and negative peer influences, including bullying, which leave youth vulnerable to self-harming behaviours.

The experiences of *adolescent girls* in *institutions*, in particular, detention in a correctional facility, introduced a number of risk factors that increased their likelihood of self-harm. The service providers in this environmental scan identified six main risk factors: separation from family, negative relations with institutional staff, poor peer relationships (negative peer influence and bullying), family histories of childhood abuse and neglect and the experience of loss within the family, mental health issues (depression and substance abuse) and identity issues. The respondents recognized how the lack of a trusting relationship with staff left adolescent girls without an outlet to deal with their complex histories of abuse and loss, their feelings of isolation and their mental health needs. They also suggested that bullying played a greater role for adolescents than for women and that it had a demoralizing impact on adolescent girls, which can lead to self-harm. It is noteworthy that these coincide to a large extent with the institutional risk factors for women, with certain exceptions, for example, the issues of self-esteem and identity, which are critical to healthy adolescent development.

Responses to Self-Harm

The service providers reported that their *women* clients most frequently were involved in the following four types of self-harm: physical self-injury (cutting and slashing), self-destructive behaviours (alcohol and drug abuse—both illegal and prescription/over the counter), destructive relationships (family violence) and expressions of suicide (suicidal thoughts and attempts). For the 2001 PWVSH and the present study, the service providers' responses were fairly consistent regarding certain guiding principles of care for women who self-harm. They identified, for example, empowerment, cultural sensitivity, and compassionate and committed staff who provide follow-up and continuity of care. A common theme underlying the responses of the service providers in both studies was the provision of on-going, coordinated and empathetic support. Some of the main guiding principles and courses of action that defined the responses of the service providers to women's self-harm included:

- Offer choices and information about the consequences of self-harm to empower women;
- Provide feedback and support to women as they progress through the stages of their healing;
- Provide support, advocacy, and access to appropriate community resources (shelters, alternative housing transportation) and make referrals to them (medical appointments, community mental health worker, an Elder);
- Ensure that there is contact with workers associated with a specific culture.

The three most common types of self-harm identified by the service providers for *adolescent girls* were physical self-injury (slashing, cutting), self-destructive behaviours

(eating disorders, sexual risk-taking, and substance abuse) and destructive relationships (childhood-based trauma and victimization). The major theme underlying the service providers' responses to self-harm among adolescent girls was the provision of care within an environment of acceptance and compassion, although they also emphasized the importance of an integrated approach based on a range of community supports and services. Some of the main guiding principles and courses of action that defined the service providers' responses to the care of adolescent girls' self-harm included:

- Encourage active participation in care to foster a feeling of empowerment, e.g., involving client in caring for wounds;
- Use a broad range of community supports and services, e.g., from referral to the appropriate agency, such as the Mental Health Association, to spiritual guidance by an Elder;
- Provide educational opportunities in comfortable settings (small groups or on an individual basis);
- Assess the client's needs within a broader social context and ensure appropriate integration of services.

In the 2001 PWVSH report, the community workers and correctional staff identified one of the most helpful responses to self-harm as having Aboriginal programs and healing approaches. In this environmental scan, a large majority of the service providers reported that they had a cultural component in their programs (supports or services) for *Aboriginal women* (77%) *and girls* (63%). These encompassed a broad range of cultural teachings, traditional ceremonies and healing approaches. The service providers described some of these for their *women* clients as follows:

- Traditional Aboriginal Spirituality using the Medicine Wheel as a teaching tool in programming;
- Programs on developing healthy relationships, including a focus on working with survivors of residential schools;
- Cultural awareness workshops, on-site sweat lodges, full-moon ceremonies, Sun Dances;
- Sharing circles with an Elder, sweats, ceremonies, awareness of history and culture;
- Availability of Elders for traditional counselling.

For *Aboriginal girls*, the service providers reported similar kinds of programming. They identified, however, some important differences. The respondents described the need for much greater inclusion of Aboriginal staff in programming and for increasing the numbers of Aboriginal foster parents. In addition, the service providers emphasized the challenge of ensuring that children claim their Aboriginal identity in a positive way. It is also important to point out that many service providers were active in referring their clients (both women and adolescent girls) to culturally-specific programs.

Recommendations

The service providers identified five main areas of recommendations for working with *women* who self-harm. These were 1. to raise community awareness about self-harm (e.g., the complex nature of self-harm as a coping mechanism); 2. to increase educational opportunities about self-harm (e.g., self-harm and suicidal intentions); 3. to provide more training on self-harm for service providers (e.g., more education and organizational workshops); 4. to increase resources for women who self-harm—from specialized programs to follow-up supports and services (e.g., need for more outreach services, follow-up, mentoring opportunities and advocacy); and 5. to address the broader social structural factors underlying women's self-harm (e.g., systemic issues of poverty, safe housing, adequate nutrition, education, child-care and employment). These were highly consistent with the recommendations proposed by the service providers in the 2001 PWVSH study. It is important to point out that while an Aboriginal approach to healing was not addressed in the recommendations, it was strongly advocated in many other sections of the environmental scan.

The service providers identified five main areas of recommendations for working with *adolescent girls* who self-harm. While these were broadly similar to those reported for women, the recommendations were oriented specifically toward the needs of adolescents. Under the first recommendation of raising community awareness, for example, the service providers pointed out the importance of distinguishing self-harm as a health issue and not just teenage rebellion. For the second recommendation of increasing educational opportunities for youth, they emphasized the importance of including parents in educational workshops. With respect to the third recommendation of providing more training for service providers, the respondents noted the need for including a wide spectrum of adolescent settings, such as foster and group homes, in order to introduce earlier interventions to troubled girls at risk of self-harm. Regarding the fourth recommendation of increasing resources, the respondents emphasized the need to include more supports and services oriented specifically toward adolescents. Under the fifth recommendation of addressing the broader social structural factors, the service providers emphasized the need for more adequate housing and shelters for youth and more counselling services for children and adolescents. Overall, the recommendations for adolescent girls were distinct from those reported for women in some important respects. There was a greater emphasis on addressing troubled family relationships, on recognizing the vulnerability of youth to sexual exploitation and the heightened risk of self-harm, and on dealing with issues of identity and self-esteem.

Next steps

In summary, this environmental scan of service providers emphasized the need for specific steps to be taken to address the issue of self-harm. The following statements outlined the need for action in certain areas:

- It is necessary to standardize definitions of self-harm and to implement systematic methods of data collection in order to assess the prevalence and types of self-harm in various settings;

- While there are studies on women's perceptions of self-harm, there is a need for qualitative research on the perceptions of youth and self-harm;
- Service providers require greater opportunities to learn about the agency or institution's policy guidelines or common practices; where these are not formulated, a forum is necessary to identify and develop policies and practices;
- Further research is necessary to explore the relationship and differences between self-harm and suicide;
- There is a lack of evaluative research on treatment and healing approaches, programs, supports and services for women and adolescent girls who self-harm; careful monitoring and evaluation of intervention strategies are essential to improve the quality of care;
- Service providers require opportunities to learn about the existing resources on self-harm, especially on the available effective or promising treatment and healing approaches;
- Public education campaigns are necessary to improve both public and professional understanding of self-harm;
- There is a persistent lack of adequate health care services for Aboriginal women, which requires immediate attention in developing culturally-specific healing approaches, programs, supports and services for self-harm; these interventions need to be designed, developed, implemented and evaluated by Aboriginal women.

The immediate next step in this research is to address the two remaining outlined goals of the project. First, the findings of this environmental scan will be shared in a Manitoba community forum, and the next steps for action will be planned with respect to developing guidelines for programs and policies. Specifically, the purpose of this forum will be to discuss the environmental scan in light of its new findings and its comparability with the 2001 PWVSH study. Drafts of the guidelines for programs and policies on self-harm will also be prepared and discussed. This community forum will be held in conjunction with the Crossing Communities Art Project and will involve the survey respondents, the Winnipeg Intersectoral Committee on Self-Harm, women who have the lived experiences of self-harming, the research team, and other key community agencies and individuals. This event is expected to take place in winter, 2005.

Second, a research project that emerged from the 2001 research study and the current environmental scan will commence in the summer of 2005. It will also be discussed at the winter 2005 community forum. Specifically, with funding from the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health, a three-year project will be undertaken to examine the role of self-identity in the healing journeys of Aboriginal women who have a history of criminalization and who are identified as drug users. The research will commence with an understanding of women's drug use as a form of self-harm. This project is a collaborative effort of Carleton University, the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse, the Elizabeth Fry Society of Manitoba and the University of Winnipeg. The goal of the study is to contribute original knowledge to the treatment field that can assist in improving the quality of health for Aboriginal women in Canada.

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