CHAPTER 11

Intersectoral and Intersectional Considerations & Recommendations

11. INTERSECTORAL AND INTERSECTIONAL CONSIDERATIONS AND RECOMMENDATIONS

Intersectoral collaboration is relational work. Women often navigate housing, legal systems, income supports, child welfare, primary care, and community support services simultaneously. When providers coordinate introductions, explain what to expect, and share information transparently and with consent, women experience systems as safer and more predictable. Co-location, warm transfers, and peer accompaniment reduce retelling and signal that services will stay with her through starts, stops, and returns. These approaches are grounded in relational, woman-centred, and trust-building practices (Centre of Excellence for Women's Health; BC Society of Transition Houses).

Women who live at the intersection of gender-based violence (GBV) and substance use often have to navigate multiple systems—primary care, emergency and public health services, housing and shelter intake, income assistance, child welfare, legal aid or family court, immigration, and sometimes criminal court.

Whether those systems recognize the whole context of her identity, community, culture, trauma history, safety, caregiving, income, disability, and migration often determines what comes next: a safe connection and some breathing space, or another door closed and a growing sense that help makes things worse.

Canada's own frameworks call us to be better. Trauma- and violence-informed care (TVIC) reminds us that violence and trauma are not side notes; they are core social determinants of health and service use. GBA Plus (Gender-Based Analysis Plus)/SGBA+ (Sex- and Gender-Based Analysis Plus) asks us to design for diversity and inequity from the outset, with disaggregated data and accountability. Together, they offer a practical way to make intersectoral care safer, more consistent, and more equitable.

Jean Tweed Centre Client

"I was lost, out of control, and suicidal. I now feel optimistic and heartened that there is a light at the end of the tunnel. The comprehensive, holistic, and integrated suite of services I have received has been invaluable in meeting my specific needs."

Women's journeys cross many systems. Safety depends on whether those systems work together as one.

- Document neutrally and plan follow-up within 3–7 days.
- Share only what she consents to and confirm next steps and timelines.
- Arrange a warm transfer (e.g., GBV services, housing, legal supports, primary care, social services, peer support, or child and family supports).
- Identify red flags related to safety, traumatic brain injury (TBI), coercion, and withdrawal risk.

PRACTICE PEARL:

All interventions addressing GBV and substance use should operate through an intersectional lens, addressing structural violence and systemic oppression.

Bohrman, C., Tennille, J., Levin, K., Rodgers, M., Rhodes, K. (2017). Being Superwoman: Low Income Mothers Surviving Problem Drinking and Intimate Partner Violence. Journal of Family Violence, 32, 699-709. DOI: 10.1007/s10896-017-9932-5.

Fear of systems shapes safety choices. Do not assume police or child welfare involvement increases safety. When racism, substance use, or prior system contact is present, prioritize non-punitive, voluntary supports that centre survivor choice and minimize system escalation.

Domestic Violence & Substance Abuse Interdisciplinary Task Force. (n.d.). Substance abuse and domestic violence: Developing a comprehensive response (2nd ed.). Illinois Department of Human Services. https://vawnet.org/sites/default/files/assets/files/2016-09/IllinoisManual2.pdf

11.1 HOW INTERSECTIONALITY CHANGES WHAT WE DO

Intersectionality is not a theory for the margins; it is everyday practice in GBV and substance use care for women experiencing GBV and substance use. It takes into account the multiple intersecting dimensions that affect, and at times compound, inequity and barriers to accessing needed care and services.

An intersectional lens for understanding the compounding and intersecting factors that drive inequitable access to support requires us to factor those considerations into how we organize clinics, shelters, court supports, and pathways to safety and support, and to measure whether the changes work for the people most affected.

Myth-busting intersectionality

Myth: Intersectionality is an add-on.

Fact: It is how we design for real-world risk and access (transport, language, identity, and income).

PRACTICE PEARL:

Gender-specific approaches are essential: treatment should consider sex-specific challenges, victimization experiences, and the moderating effects of gender on substance use and recovery.

Health and treatment differences:

- Women experience more severe opioid withdrawal symptoms than men.
- Women experience higher opioid-related cravings and overdose risk.
- Women are less likely to be prescribed Narcan following a suspected overdose and less likely to receive a direct referral to treatment or follow-up after an emergency department (ED) visit.

Huhn, A., Dunn, K. (2020). Challenges for Women Entering Treatment for Opioid Use Disorder. Current Psychiatry Reports 22(76). Tubman, J. G., & Galo, G. E. (2025). Lifetime adversity and risky substance use among transgender emerging adults: Selected interventions and clinical social work practice. Clinical Social Work Journal, 53, 32–42. https://doi.org/10.1007/s10615-024-00967-6

Motz, M., Andrews, N. C., Bondi, B. C., Leslie, M., & Pepler, D. J. (2019). Addressing the impact of interpersonal violence in women who struggle with substance use through developmental-relational strategies in a community program. International Journal of Environmental Research and Public Health, 16(21), 4197. https://doi.org/10.3390/ijerph16214197

11.2 HEALTH, EMPLOYMENT, AND EVERYDAY SERVICES: THE ACCESS GAP

In the intake room or during an admission phone call, access is often determined by language, health literacy, paperwork, and how we ask about what women need most and their strengths. Women juggling GBV and substance use describe avoiding care because of stigma, fear of child welfare involvement, or prior experiences of being dismissed or disbelieved. TVIC and equity-oriented care demonstrate tangible actions that can improve outcomes. For example, introduce “screening” by asking about substance use and GBV as routine for everyone; check privacy before asking; mirror preferred names and pronouns; explain what will (and will not) be documented; and design spaces and policies that feel safe for people who have every reason not to trust systems that may have broken their trust.

At the policy level, Canada’s National Action Plan to End GBV and the federal GBV Strategy call for survivor-centred supports and better intersectoral coordination—across health, social infrastructure, and justice—so that people do not have to choose between safety, treatment, employment, and care of children. Sex and Gender-Based Analysis Plus (SGBA+) guidance in federal departments expands this to equitable program design, disaggregated data, and accountability —mechanisms that turn good intentions into durable access.

Employment and income are determinants of health. Survivors report job loss due to missed shifts and court dates; others fear that disclosure to an employer could cost them their jobs. Equity-oriented policies—from paid leave for violence to flexible scheduling in substance use disorder care and employer education—reduce harms that otherwise are addressed downstream in emergency rooms, shelters, and child protection systems.

PRACTICE PEARL:

External barriers, such as judgmental attitudes from service providers and social stigma, can lead to self-stigma. Isolation may lead women to withdraw from public life and continue using substances to forget, suppress, or reduce negative feelings arising from shame.

Schamp J, Vanderplasschen W, and Meulewaeter F (2022) Treatment providers' perspectives on a gender-responsive approach in alcohol and drug treatment for women in Belgium. Front. Psychiatry 13:941384. doi: 10.3389/fpsyt.2022.941384

11.3 LEGAL AND JUSTICE SYSTEM IMPACTS: PATTERNS, NOT ONE-OFFS

Women experiencing both gender-based violence (GBV) and substance use are often subjected to coercive control long before any assault is reported. This can include surveillance, threats, isolation, economic abuse, and the forced or sabotaged use of substances, as well as post-separation litigation tactics that drain time and financial resources. Canadian family law increasingly recognizes patterns of behaviour—not isolated incidents—as constituting family violence. For frontline documentation and advocacy, this underscores the importance of recording "course of conduct" evidence (e.g., ongoing monitoring, financial control, technology-facilitated harassment), rather than focusing solely on physical injuries.

Criminal law reform in Canada is also evolving. Bill C-332, which addresses coercive control, passed the House of Commons and advanced to the Senate in 2024, signalling a shift toward earlier intervention in patterns of harm. In 2025, federal proposals expanded on this direction, aiming to criminalize coercive control as part of a broader legislative framework. At the same time, Canadian scholars caution that without careful implementation—including training, public legal education, and safeguards within immigration and family law systems—criminalization may not adequately protect those at greatest risk and could lead to unintended consequences.

PRACTICE PEARL:

External judgment and societal expectations can shape how women choose to respond, often leading them to carefully manage their perceived image to protect their safety, dignity, and sense of control. In unsupportive environments, women may face additional barriers to disclosing gender-based violence or seeking help.

Alcantud, P., Campdepadros-Cullell, R., Fuentes-Pumarola, C., Mut-Montalva, E. (2020). 'I think I will need help': A systematic review of who facilitates the recovery from gender-based violence and how they do so. Health Expectations 24(1), pp. 1-7. https://doi.org/10.1111/hex.13157

11.4 HOUSING AND HOMELESSNESS: WHEN SAFETY MEANS MOVING AGAIN (AND AGAIN)

Housing is where GBV and substance use intersect most painfully. Women often reduce risk by moving repeatedly—to a friend's couch, a motel, a new partner's home, or a shelter two cities away.

Much of this reflects hidden homelessness and is therefore undercounted. Statistics miss the nights spent avoiding the streets by entering unsafe arrangements. Gender-responsive evidence points to what works: coordinated pathways across GBV services, housing programs, primary care, and income supports, with TVIC at the centre so the journey out of violence is not itself dangerous.

Canadian analyses emphasize tailored, women-centred housing (and adaptations of Housing First for women and gender-diverse people), along with rapid, low-barrier access from hospitals, GBV services, and courts. These approaches reduce the "choice" between staying with a person using abusive behaviours, engaging in survival sex, or returning to substance use in unsafe contexts. Women-focused guidance also highlights that mother–child models that stabilize housing and support recovery and parenting are key to sustainable exits.

PRACTICE PEARL:

Discrimination is a lifelong adversity that many people experience. It is essential to have open conversations with clients about how discrimination might be connected to their experiences of GBV and/or substance use.

Tubman, J. G., & Galo, G. E. (2025). Lifetime adversity and risky substance use among transgender emerging adults: Selected interventions and clinical social work practice. Clinical Social Work Journal, 53, 32–42. https://doi.org/10.1007/s10615-024-00967-6

One size never fits all.

Adapt safety planning to system risks (immigration, child welfare, policing, rurality).

IMMIGRATION | CHILD WELFARE | POLICING | RURALITY

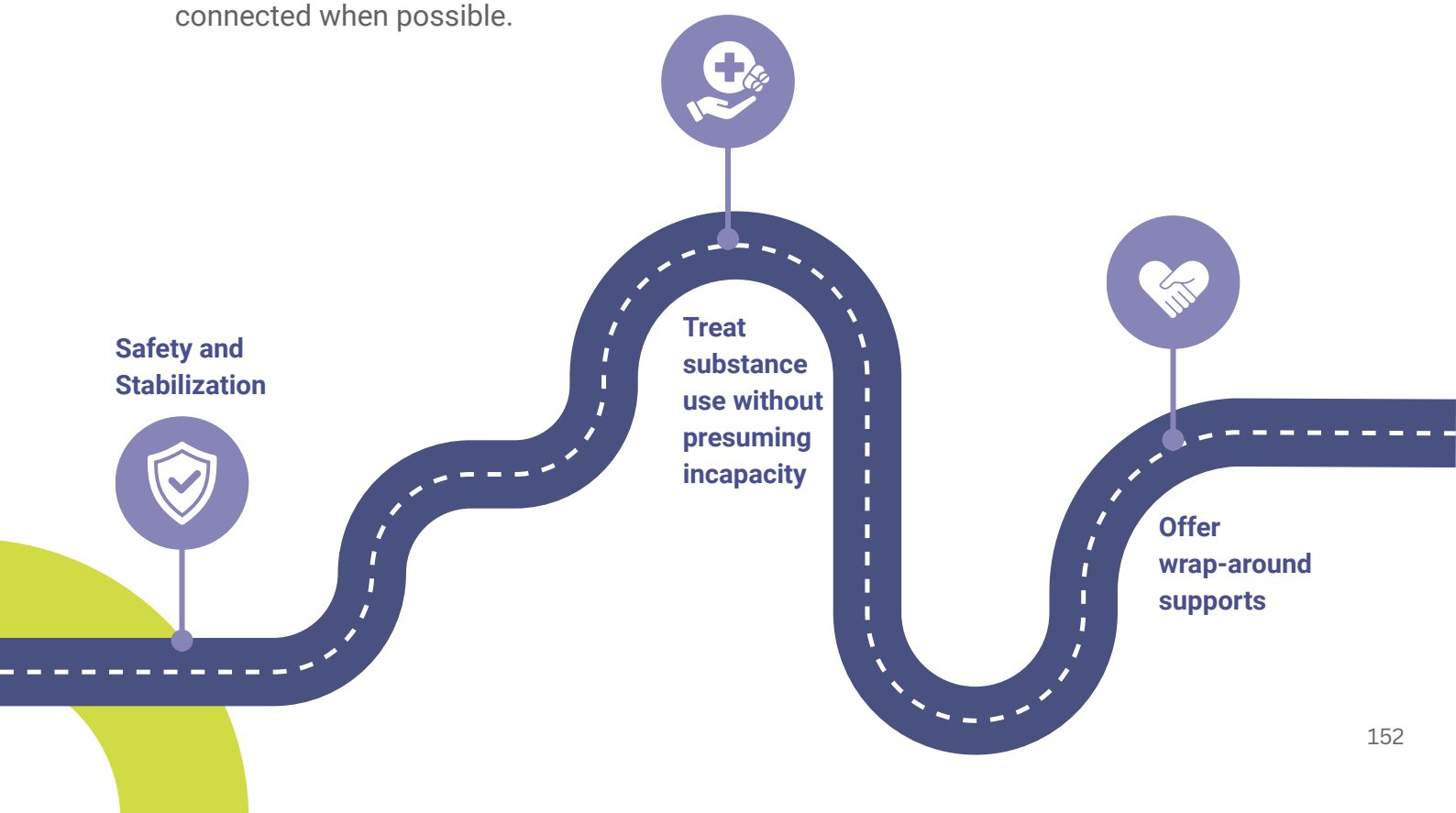
What would make today safer?

11.5 CHILD-WELFARE: SEPARATING RISK FROM SUPPORT

When GBV and substance use intersect, women often anticipate that seeking help could lead to a child welfare report. Fear is not unfounded; across Canada, surveillance-heavy responses can conflate perpetrator risk with a mother's coping (including substance use as a trauma response).

TVIC offers a different path: begin with safety and stabilization; treat substance use without presuming incapacity; offer wraparound supports (parenting, attachment-based care, kinship options) that keep children safe and keep families connected when possible.

The MMIWG Calls for Justice include specific obligations for social workers and child welfare systems: uphold rights, reduce removals, and implement culturally grounded services that reflect community definitions of well-being. In practice, that means Indigenous-led planning, accountability to communities, and pathways that avoid turning help-seeking into punishment.



11.6 INDIGENOUS WOMEN AND 2SLGBTQQIA+ PEOPLE: HONOURING SELF-DETERMINATION

The National Inquiry into MMIWG names the colonial roots of violence and calls for transformative, intersectoral change and systems that honour Indigenous jurisdiction and knowledge across health, justice, housing, social services, and child welfare. The Inquiry also recognizes the disproportionate violence experienced by Indigenous women, girls, and 2SLGBTQQIA+ people, and the importance of affirming gender diversity, cultural identity, belonging, and self-determination in all responses.

For care workers, the implications are immediate: partner with Indigenous leadership; embed culture, land, language, and Elders; create inclusive and affirming spaces for Indigenous women and 2SLGBTQQIA+ people; and treat self-determination as an evidence-based safety practice.

11.7 WHAT COORDINATED, EQUITY-ORIENTED SYSTEMS LOOK LIKE (CANADA'S LEVERS)

Canada's National Action Plan to End GBV (five pillars) and the federal GBV Strategy (three pillars) provide a shared framework for provinces, territories, and municipalities. Provincial action plans (e.g., Ontario STANDS) and local community action plans show how intersectoral tables can drive no-wrong-door pathways. Sector-specific guidance (e.g., women's substance use treatment and recovery) and anti-racism/anti-oppression frameworks help organizations turn intersectionality into daily practice—across spending power, hiring, space, schedules, data, and partnerships—so the system reflects whom it serves.

11.8 RECOMMENDATIONS

Make it a single system on the ground. Establish local GBV and substance use tables with decision-making authority to map no-wrong-door pathways (health, GBV, housing, legal, child welfare, settlement, Indigenous partners). Track equity using disaggregated data and lived-experience feedback.

Hard-wire TVIC and SGBA+ into policy and programs: standard privacy checks, non-stigmatizing documentation, interpreter access, flexible appointments, staff debriefing and supervision, and warm-transfer expectations across agencies.

Health and Substance Use (SU) services: Offer universal SBIRT with LIVES and harm reduction; ask about substance-use coercion and strangulation/traumatic brain injury (TBI); embed mother–child and women-centred programming to reduce care, work, and parenting conflicts.

Housing: Create rapid, women-centred pathways (including Housing First adaptations) from hospitals, courts, and GBV services; measure hidden homelessness and successful contacts, not just referrals made.

Justice & child welfare: Train on coercive control; document patterns; align family, criminal, immigration, and child welfare systems to avoid penalizing help-seeking; if criminal reforms proceed, pair them with training and safeguards to prevent unintended harms.

Indigenous leadership: Support Indigenous-designed services and local implementation of the Calls for Justice with transparent accountability.