Title: Virtual communities as locations for catalyzing research to praxis

Student: Nancy Poole
B.A., Diploma in Child Study (M.A. equiv.), M.A. Distributed Learning

Institution: School of Education, University of South Australia

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Glossary and abbreviations

CoP – community of practice

CCSA – Canadian Centre on Substance Abuse

CR – consciousness raising

FAS / FASD - Fetal Alcohol Syndrome / Fetal Alcohol Spectrum Disorder, a group of life long disabilities resulting from significant prenatal alcohol exposure

FPAR – feminist participatory action research

SGDBA – Sex- gender- and diversity-based analysis

vCoI – virtual community of inquiry

vCoP – virtual community of practice

Summary

The study was inspired by the increasing interest on the part of national research funding bodies and international health organizations in improving the application of health research to practice and policy. Knowledge translation practice as it has been enacted to date is examined, specifically the advances toward mechanisms that involve a range of end users, together with researchers, in co-construction of knowledge. Further, the study is based in the need to bring expertise in sex- and gender-based analysis and other feminist research practices to such national and international discourses and knowledge translation approaches, with the goal of reducing inequities in health in the course of bringing knowledge to action.

The thesis describes the design, implementation and outcome of a virtual community of inquiry, constructed to be a location, and potentially a model, for knowledge translation on complex, gendered health issues. The virtual community created and studied, involved researchers, health practitioners, policy analysts and educators in collective, participatory, online engagement with evidence related to women's health and substance use. This virtual community was enacted in Canada in 2009, involving participants who had been engaged in defining a national framework for action on substance use; yet may be seen to have relevance for researchers and educators interested in knowledge translation to achieve health equity goals in other developed and developing countries.

Evidence was used and integrated from three fields to design, implement and analyse this virtual community of inquiry: feminist theory and practice, situated and transformative learning theory and practice, and technologically supported learning. Principles from feminist participatory action research and feminist pedagogy were employed including the enactment of inclusion and levelling of epistemic privilege. Evidence from situated

and transformative learning as applied in communities of practice is discussed as foundational to the design of knowledge translation contexts, where paradigmatic shifts in perspective are desired. Contributions from the study of virtual communities of inquiry, specifically social, cognitive and teaching presences, are identified as that particularly helpful to support and extend virtual learning.

The case is made for the need for enhanced knowledge translation models that support the conceptual and strategic application of knowledge for complex contexts such as the addictions field. Further is it argued that knowledge translation processes have worked in largely gender-blind ways; and that models of feminist praxis such as consciousness raising groups and feminist participatory action research offer remedies to the lack of integration of sex/gender in health, as well as to narrow, hierarchical approaches to knowledge translation. The community illustrated that transdisciplinary and multisectoral engagement, collective exploration and synthesis of multiple forms of evidence, and critical, collective consideration of options for improving policy and practice is made possible in virtual communities of inquiry. Further, in such virtual communities of inquiry, in the course of engaging with multiple forms of evidence, and fully considering the context from which the evidence arises, researchers, health practitioners, policy analysts and educators have the opportunity to participate in critical thinking on gender in an inter-subjective space as engaged scholars, in a way that invites gender-informed action.

Declaration

This thesis presents work carried out by myself and does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; to the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text; and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.



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Chapter 1 - Introduction

The memories of consciousness-raising groups and street-based action in the 1970s which were foundational to improvement in the status of women are growing more distant. New technologically supported forms of communication are inviting rethinking of how to act collectively, to achieve feminist goals. New expectations of researchers to proactively share their findings in ways other than publishing in academic journals have emerged. For researchers too, technologically supported forms of communication can support research-to-practice and research-to-policy aims. It is now possible to build virtual communities to support broad knowledge dissemination as well as feminist participatory action research goals from our desktops. Shall we resist or embrace technological advances enabling communication and collective action planning in virtual communities? This thesis is concerned with is the potential of virtual communities as mechanisms for facilitating collaborative knowledge exchange, promoting knowledge synthesis and catalyzing action on bringing knowledge on women's health to praxis.

1.1 Situating myself

Over the past decade, researchers at the British Columbia Centre of Excellence for Women's Health in Canada (where I am located) have been facilitating multi-sectoral collaborations related to research involvement and knowledge exchange on women's health issues. In 2001, the Fusion model (Greaves & Ballem 2001) was collectively developed, describing the Centre's emergent approach to addressing the challenges associated with defining and creating authentic inter-sectoral research partnerships, addressing inherent issues of power and conflict and integrating knowledge exchange throughout all stages of the research process. This collaborative, multi-sectoral Fusion approach challenges the conceptualization of knowledge as derived from academic research alone, and of knowledge translation as a two-way exchange; and embeds researchers in interactive and egalitarian context that respects different knowledge bases. Using the Fusion model, the Centre has made multi-sectoral involvement of researchers, decision makers, health practitioners, and women's health

advocates central to all research endeavors. As such the Fusion approach supports reciprocal, multi-directional, social learning.

As technology became available, we at the Centre began to use virtual methods for engaging other researchers and the three types of end users of evidence on women's health (practitioners, policy analysts/health system planners and women with health concerns/women activists at the community level). Since 2004, I have been inviting researchers, health service providers, health system planners/decision makers and women invested in specific health issues into virtual learning communities to collaboratively share, review and synthesize knowledge, and discuss how to bring these co-constructed syntheses into practice, policy, and further research, in ways that will improve the health of women with substance use problems.

I first used room-based[1] videoconferencing capacity for engaging distributed researchers, health service providers, women interested in health care, and decision makers in learning of current research on pregnancy and substance use, and discussing the implications for practice in policy (Poole 2004). Given the further technological developments in *desktop* videoconferencing, I am now able to invite participants to connect to webmeetings from their desks and to create web-based workspaces that together provide a platform for sharing, discussing and synthesizing knowledge on issues related to women's substance use. This use of technology has allowed for expanded involvement that bridges distance and other forms of diversity, with the potential for much broader exchange and application to practice and policy. Web-based meetings and workspaces also invite scrutiny as new locations where different learning strategies can be enacted for collective adult learning and for action planning towards achieving gender equity.

As I was designing these virtual learning communities on marginalized women's health issues, I realized that I was drawing on earlier experience of co-construction of knowledge and activism on women's health and social justice issues. I had participated in a feminist consciousness raising (CR) group in the 1970s where we shared our

[1] In the health system in Canada, room based videoconferencing (where people come to a site which is equipped with cameras, audio and other equipment for a videoconferenced session to be linked to select other sites) is often called Telehealth

experiences, made connections among diverse experiences, synthesized this collective discussion to form new understandings of our experiences as 'violence against women' and brought this understanding into action[2]. I also realized that I needed to study collective, online learning processes, to link them to the powerful early CR experience, in order to understand the potential of virtual communities as forums for gender-informed practice of knowledge translation/exchange.

As such this study weaves together three emerging interests:

- involving multi-sectoral participants in extended research processes on women's health (i.e. research processes that include translation of research to practice, policy and community);
- employing and examining the potential of virtual methods, specifically virtual communities, for supporting such comprehensive, multi-sectoral processes; and
- utilizing practices grounded in feminist, critical and social learning theories to design and analyze such processes.

In this research, and in other inclusive virtual community processes I have facilitated over the past decade[3], my involvement is both as a participant and as a researcher/facilitator. This multi-faceted role requires consciousness of one's identity and ideology, care not to impose one's will or colonial privilege, belief in the potential for co-construction of knowledge though dialogue, and humility as a learner (Berryman, SooHoo & Nevin 2013). The insider-outsider role in feminist participatory action research has been discussed as requiring considerable reflexivity (Hemmings 2012; Hesse-Biber & Piatellli 2007; Kirby, SL, Greaves & Reid 2006). In this case another level of complexity is added, given the involvement of participants from multiple sectors, each with differing levels of epistemic privilege (as traditionally assigned); as opposed to balancing a dualistic researcher-participant power relationship. Additionally

[2] Members of my CR group in Toronto in the 1970s were focused on bringing experiential theorizing on violence against women into practice through involvement in establishing a shelter for women and children leaving violent circumstances (Nellies Hostel, www.nellies.org) and an activist organization Women Against Violence Against Women

[3] Including at the time of writing leading a largely virtual Network Action Team of over 60 researchers, practitioners, policy analysts and mothers from across Canada for the CanFASD Research Network See http://www.canfasd.ca/research-teams/prevention/prevention-from-a-womens-health-determinants-perspective/

in this study, I engage with the role of researchers such as myself as engaged scholars as opposed to neutral conveyors of scientific evidence.

The aim of this research is to describe a case of a virtual community of inquiry on the topic of women's substance use, involving distributed, multi-sectoral participants in Canada; and to consider its processes and outcomes in the light of current practices within knowledge translation, feminist action research, and transformative learning fields. This study is concerned with the potential of virtual communities as locations where research, and other forms of evidence on complex women's health issues can be shared and collectively synthesized, and where routes for action on this knowledge (translation into practice, policy and further research) can be identified. In the course of achieving this research aim, this thesis is also a narrative of my learning, and as will unfold, a re-situating of myself as an engaged scholar.

1.2. The context and potential contribution of this study

The following contextual developments have sparked my interest in this research area and offer potential for it to make a contribution to the practice of gender-informed knowledge translation on complex health issues.

Worldwide interest in and attention to knowledge translation in health

Increasingly research funding bodies such as the Canadian Institutes for Health Research, governments at all levels, and international organizations such as the World Health Organization have shown interest in improving the application of health research to practice and policy (Graham, Ian D. & Tetroe 2009; World Health Organization 2006). This study will make a contribution to this discourse about, and practice of *knowledge translation* in the health research field. Knowledge translation has been defined by the Canadian Institutes for Health Research as "the exchange, synthesis and ethically-sound application of knowledge - within a complex system of interactions among researchers and users - to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products, and a strengthened health care system *(Canadian Institutes of Health Research Act*, *CIHR website*). This thesis is designed to add to the understanding of knowledge translation

processes which: intentionally engage diverse end users; are focussed on the adaptation (over the adoption) of knowledge; actively take on complex social problems; and situate researchers as engaged scholars in the process. In this research a knowledge translation model will be implemented and examined, one involving collaborative examination, synthesis and generation of knowledge, thereby adding to this discourse. It will compare and connect this model to current theorizing and developments in the knowledge translation field.

Interest in applying gender-based analysis as a foundation for fostering action to improve women's health.

The BC Centre of Excellence for Women's Health and other women's health advocates worldwide have identified the need for forums or mechanisms for promoting understanding and action on persistent gender inequities in health (Clow et al. 2009; Sen & Ostlin 2010). Knowledge exchange models often focus on narrow instruction for health care practice, rather than promoting understanding and action on addressing gender and other determinants of health. Beyond *joining* the existing discourse on knowledge translation, there is a need to bring to it expertise in gender-based analysis and other feminist research practices with the goals of promoting reducing inequities in health.

Opportunity to capitalize on relationships and developments within the substance use field, as a context in which to invite engagement with research and other sources of knowledge on gender issues

The substance use field in Canada is in an important phase of change, creating a potential, positive opening for inviting attention to gender. In the past five years, significant achievements have been realised towards implementing evidence-based practice and harm-reduction-oriented approaches (Addiction Services Alcohol Task Group 2007; Government of British Columbia 2010; National Treatment Strategy Working Group October 2008). These developments have required paradigmatic shifts in practice, and have involved a much wider, national engagement in defining policy and practice. These developments denote a potential systemic capacity for transformative learning. Yet there remains a lack of understanding of sex and gender influences on substance use, a lack of attention to the gendered impact of stigmatization and marginalization of women substance users, and a tendency to see women as a 'special

population', with a resultant lack of systematic and systemic commitment to tailor prevention, treatment and harm reduction responses to take gender and women's diverse needs into account in service delivery and policy implementation. This thesis describes virtual communities as possible forums for bringing together those in a position to implement gendered approaches to substance misuse, to discuss evidence and consider the application of this evidence in multiple contexts.

The emergence of communities of practice as mechanisms for situated learning

Social, situated learning (situated in the context of one's daily work and living, inherent in practice, located locally not in educational institutions) has had considerable attention in the adult learning field in the past decade. Wenger and colleagues (Lave & Wenger 1991; Wenger 1998; Wenger, McDermott & Snyder 2002) have explored key concepts of social learning within communities of practice. In the knowledge translation literature in the health field, communities of practice have been mentioned as providing "the ideal conceptual framework for knowledge integration and translation (Palmer & Kramlich 2011, p. 32), that optimally support "managing the conceptual, instrumental and strategic use of knowledge" (ibid). In this study, it is of interest to see how/if benefits in learning and agency can be achieved through interacting in a short-term community of practice. And can a multi-sectoral group, as opposed to those from one profession or discipline, as typical in communities of practice, be held together by a common sense of purpose about extending their practice related to gender? How is individual and collective inquiry facilitated in online communities? Further might communities of practice or inquiry serve as a model for knowledge translation on complex health issues?

Technological capacity is available to support engagement in virtual communities of inquiry through webmeetings, webspaces and related mechanisms.

Increasing technological capacity to support adult learning in the online environment is available. As practitioners, health system planners and researchers, we need to synthesize massive amounts of information, and consider how to adapt it for application in specific contexts. It is an opportune time to consider the potential of online learning and inquiry in community to achieve these ends, and the role of the researcher in this process.

1.3 The research question and design

The research question for this study builds on these interests in knowledge translation, feminist participatory action research and new connective technologies, and is attuned to the challenges of linking and applying participatory, theory-based approaches to knowledge translation in highly complex contexts such as the substance use field. The research question for this thesis is "**How can short-term, multisectoral, virtual communities foster the application of co-constructed knowledge on marginalized women's health, and contribute to the understanding of both knowledge translation and contemporary feminist action research?**"

1.4 The structure of this thesis

The structure of this thesis is as follows:

Following this introductory chapter, Chapter 2 considers knowledge translation practice as it has been enacted and studied in Canada and other western societies. It focuses on what has been learned about the application of knowledge translation in complex contexts, including how gender is currently being addressed. The virtual community featured in this thesis is designed to be a location for knowledge translation, and potentially a model for the enactment of knowledge translation on complex health issues. Thus this chapter sets the context for the study in the current practice of knowledge translation in Canada, and the specific evidentiary and activist challenges related to knowledge translation on marginalized women's health issues, such as women's substance use.

Chapter 3 describes the methodology and methods of the study and locates the study in the broad territory of action research. It describes how a range of research paradigms, as well as feminist and social learning theories was drawn upon in the design and study of this virtual community of inquiry. It outlines the detailed methods employed for the virtual infrastructure, participant recruitment, data collection, and data analysis. In total, it explains the methodological underpinnings of the study of a virtual community designed to serve as an innovative model for knowledge translation on marginalized women's health.

Chapter 4 describes the enactment of the virtual community. It provides a picture of the participants the virtual community attracted, their motivations for joining, their experience of the virtual environment, the topics discussed, as well as the nature of those discussions. As such the chapter provides an overview of this exemplar of a virtual community built to achieve goals foundational to knowledge translation, feminist participatory action research, transformative learning and distributed (virtual) involvement.

Chapters 5 and 6 present the findings from the lenses of: feminist praxis and pedagogy, and social and transformative learning as applied in communities of practice. Aspects of the community featured in this study are considered in the light of these theoretical and pedagogical frameworks. In these chapters, reflection is made on the potential contributions of feminist praxis and pedagogy, and social learning in communities of practice/inquiry to the enactment of knowledge translation in complex contexts where paradigmatic shifts in perspective are desired.

In Chapter 7, what is known generally about the opportunities opened up by online learning mechanisms and processes will be considered; and how virtual communities can employ and extend the use of these online learning processes. The elements of virtual communities that support knowledge exchange, synthesis and application in contexts such as this study are described.

The final chapter ties together how three fields of knowledge – feminist theory and praxis, social and transformative learning, and effective approaches to virtual learning – can inform the design and implementation of virtual communities with knowledge translation goals. The lessons learned in this case study of the application of principles and practices from feminist participatory action research, communities of practice and inquiry and virtual communities are summarized. And a general statement is made about the potential of virtual communities of inquiry as locations for knowledge sharing, knowledge synthesis and catalyzing of gender-informed action on complex health issues.

Chapter 2 – Whither knowledge translation?

As stated in Chapter 1, this research is concerned with the potential of virtual communities as locations where research, and other forms of evidence on complex women's health issues can be shared and collectively synthesized, and where routes for action on this knowledge (translation into practice, policy and further research) can be identified.

This chapter considers knowledge translation as it has been conceptualized, enacted and studied in Canada over the past several decades. It focuses on what has been learned about the practice of knowledge translation, including how consideration of gender is currently being incorporated in its content and processes. It provides some context as to the extent to which gender has been taken into account in substance use research, practice and policy initiatives in Canada, and the resultant need for bringing gendered knowledge to action in that field.

Learning about knowledge translation as it has been conceived and enacted by others was the initial central aim for undertaking this doctoral work. This chapter focuses on the evidence related to knowledge translation, on its application in the context of the substance use field, and the need for improved knowledge to action efforts and mechanisms for the field, particularly in relationship to bringing evidence on women's substance use to the fore.

These developments in knowledge translation in general, and knowledge translation in the substance use field are presented with a view to how they align with historical efforts by feminists to provoke action on women's health, grounded in the evidence for sex and gender differences in health, access to health care, and gendered responses by the health care system. Together they create the foundation and justification for this research.

2.1 Background on knowledge translation

Traditional knowledge translation models in health were based in fundamentally different views of research, researcher, end users of knowledge, and knowledge exchange than current conceptualizations. Simplistically, in early models knowledge was typically seen as empirical in nature, created by the researcher as 'expert', transferred from 'top down', through one-way instructive learning processes, to practitioners who were not 'epistemologically active' (Broner et al. 2001, p. 82). Later views saw the challenge as one of bridging a gap between research and practice in ways that involved interactivity and exchange with practitioners (Graham & Logan 2004). From there, the lens widened to see not only health practitioners as the end users of evidence, but also health system planners, decision makers, and policy makers (Bowen, Martens & The *Need to Know* Team 2005; Ginsburg & Gorostiaga 2006; Lavis 2006).

While one-way, didactical methods are still in play, mechanisms that involve end users in co-construction of knowledge are now advocated (Kothari & Armstrong 2011; Rycroft-Malone & Bucknall 2010). These newer conceptions of knowledge exchange identify how it is important to connect researchers, practitioners and policy makers in ways that support all participants as both knowledge users and producers (Henderson et al. 2013; Jansson et al. 2010). Networks and communities of practice, various non-linear exchange processes, change management, and integrative and interactive processes are all being applied as mechanisms for, and approaches to knowledge exchange and application (Bertone et al. 2013; Conklin et al. 2013; Kothari et al. 2005; Sinfield et al. 2012; Walter, Nutley & Davies 2005; Wathen et al. 2011).

While refinements are being documented as to who needs to be involved in knowledge translation, and how to address context-specific barriers to their involvement (Tugwell et al. 2006), less common is documentation of knowledge translation strategies that involve multiple holders of different kinds of knowledge, in multi-directional collaborative learning and consensus building processes. An exception is Greenhalgh and colleagues' prescription for theory-driven, process-oriented, ecological, collaborative, multidisciplinary and participatory knowledge translation (Greenhalgh et al. 2004).

Indeed Greenhalgh and colleagues shifted the conversation on knowledge translation in 2004 with the publication of their systematic review of the literature on diffusion of innovations in health service delivery and design in the Milbank Quarterly (Greenhalgh et al. 2004). This review was exemplary in its meta-analytic approach that included the literature and innovations in multiple fields which were relevant to healthcare and health systems: they drew, for example, from rural and medical sociology, health promotion, evidence-based medicine, and organizational and management literatures. From this base, they proposed a groundbreaking conceptual model for considering the determinants of diffusion, dissemination and implementation of innovations, with elements that included: the attributes of the innovation, the attributes of the adopter, a wide range of contextual factors such as system antecedents and readiness, and a number of qualities of the implementation process. Using this conceptual model, they made specific suggestions as to what questions would move the knowledge translation field forward (p. 617):

- *Adopter* – They discouraged further studies of patterns of adoption by individuals and recommended, for example, that researchers look to the transferable lessons from cognitive and social psychology about the ability and tendency of individuals to adopt particular innovations in particular circumstances.
- *Diffusion and dissemination* - They discouraged further trials of the use of opinion leaders to change the behaviour of potential adopters, and instead to consider who are the individuals who act as boundary spanners among health service organizations, especially in relation to complex service innovations. They saw the need to understand the nature of the boundary spanner role and how might it be enabled and enhanced; and the need to examine how social networks serve as channels for social influence and the reinvention and embedding of complex service innovations.
- *Organizational context* - They saw that the effect of structural determinants was well established, yet many questions remained about context at the organizational level, such as how the absorptive capacity of service organizations for new knowledge can be improved.
- *Outer context* - They saw the importance of describing the nature of informal inter-organizational networking in different areas of activity, and asking how can this be enhanced through explicit knowledge management activities

- *Implementation process* – They invited consideration of what processes are particular innovations in health service delivery and organization implemented and sustained (or not) in particular contexts and settings, and of how these processes be enhanced.

They recommended (pp. 615-6) future research on knowledge translation be:

- theory driven;
- process oriented (asking what features account for success or failure);
- ecological (recognizing the reciprocal interaction between the program and the wider setting in which it takes place);
- collaborative and coordinated (across multiple programs in a variety of contexts);
- multi-disciplinary and multi-method; and
- participatory (involving the service providers as partners in the research process).

This thesis takes up these challenges by linking feminist and transformative learning theories to guide an approach to knowledge translation. The knowledge translation approach studied involves participatory virtual processes, by multidisciplinary adopters, who engage together as boundary spanners, in the consideration of evidence, gendered context, innovation and online collaboration in order to improve health service policy and practice.

Another influential research team involved in the study of knowledge translation has summarized successful efforts to bring research into practice and policy as a function of three factors: the nature of the evidence to be shared and applied, the qualities of the context of implementation, and approaches to facilitation (Helfrich et al. 2010; Kitson, Harvey & McCormack 1998; Kitson et al. 2008; Rycroft-Malone et al. 2004a). This PARiHS framework (Promoting Action on Research Implementation in Health Services) "has proved to be a useful practical and conceptual heuristic for many researchers and practitioners in framing their research or knowledge translation endeavours" (Kitson et al. 2008, p. 2). Thus to organize the discussion of knowledge translation overall, knowledge translation in the context of the Canadian substance use

field, and the consideration of gender in knowledge translation efforts to date, and I will use these three elements of the PARiHS framework: evidence, context and facilitation.

2.2 Evidence

2.2.1 The evolving discourse about evidence in the knowledge translation field

The Canadian Institutes of Health Research have been keen to get researchers to think about the "synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system" (Straus, Tetroe & Graham 2009, p. 4). A key concern underlying this push has been that clinical research evidence was not getting applied in timely way: in the US a 25 year lag has been cited between research and application to practice in cardiovascular health, and in the UK it has been estimated that the delay between research and impact on treatment is 10-25 years in cardiovascular health and 9-14 years in mental health (Health Economics Research Group Office of Health Economics RAND Europe 2008).

From the 1990's on, a focus has been placed on evidence based practice or medicine, causing Rycroft-Malone and colleagues (2004b, p. 82) to state "Evidence may well be one of the most fashionable words in health care". These PARiHS authors trace the discourse on 'evidence based medicine' pointing out how in that discourse "there was a common assumption that evidence was research evidence and, more specifically, research evidence from the quantitative tradition" (p. 83). They pointed to the pre-eminent valuing of the randomized control trial, the undervaluing and neglect of other forms of evidence, and the importance of contextual, tacit knowledge in nursing practice. Other knowledge translation experts have pointed out how little evidence there is for an evidence based approach in the sense of linking research to use for improved service outcomes (Nutley, Walter & Davies 2007) and that instead we need to build on what we know about the processes of research use and on combining research with other forms of knowledge.

Researchers have also noted how evidence from research has been privileged in various ways, in particular research involving quantitative methods using large data sets

(Labonte et al. 2005; Maclure 2007), over a blend of four sources of evidence proposed by Rycroft-Malone and colleagues (2004b) which include: research, knowledge from clinical practice, personal knowledge and experience of patients, and data from the local context. Kitson (2008, p. 1) summarizes this issue in an editorial in the International Journal of Evidence Based Health Care:

> *our problem is that we still tend to see evidence as a product, a commodity, a thing that can be put into a system. Indeed evidence is a complex construction of facts, propositions, experiences, biographies and histories and ultimately an exercise of judgement bounded by time and context.*

Other concerns have included the privileging of new knowledge over assimilation and reinvestment of what is already known (Bass 2005, p. 102; World Health Organization 2004) .

The need to identify, respect and even map tacit practice knowledge has also been discussed (Hay et al. 2008; Landry et al. 2006; McWilliam, Carol L et al. 2009). In the policy context, Pang (2007, p. 247) has described how important it is in global application of evidence to rely not only on randomized control trials but also on observational studies, qualitative research and even "experience", "know-how", consensus and "local knowledge". Court and Young (2003) added that for successful knowledge translation in the policy context, the evidence needs to be credible, convincing and providing practical solutions to immediate policy problems. In fact for 'solutions' to be generated in what Nowotny describes as Mode-2 knowledge production (Nowotny 2006), knowledge is required from many fields, and work is needed at the boundaries of disciplines (Carlile 2004).

The CIHR added to its definition of knowledge translation a description of the need for interactivity: "This process [knowledge translation] takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge users" (Canadian Institutes of Health Research). As such, for feminists, the need is to understand the ways in which to catalyse and support such interactivity with the evidence we have on sex and gender differences in health, as well as the contexts for, and levels of openness to, its application. Overall the challenge is one of reconciling

positivist and interpretative approaches to generation and application of evidence, to honour that "evidence itself is much more a relative concept than proof" (McNeill 2006, p. 150) and that knowledge work is needed that exposes the dominant ideologies and discourses that shape the information accessed by many individuals (Kincheloe n.d.).

Nutley and colleagues (2007, p. 37) discuss not only the direct use of research to make decisions (instrumental use of research) but indirect or conceptual use of research that reshapes thinking around policy and practice problems or plays "a more 'consciousness-raising role'" (p. 2). In conceptual research use, the focus is not only to convey research findings, but instead to promote the assimilation of research ideas, theories and concepts into discourse and debates. This conceptual use of research, in a paradigm-challenging approach (Nutley, Walter & Davies 2007, p. 12) is highly relevant to the task of bringing sex-and gender-based analysis and action to substance use policy and practice.

In the case of bringing evidence to policy, a uni-dimensional use of research evidence has been criticized as an "unrealistically simple account of policy making" (Smith, KE & Joyce 2012, p. 57). Based on work in Zambia related to HIV and other complex health issues Kasonde and Campbell (2012, p. 1) offer: "Often misunderstood as a technique to transfer research findings directly to policy, KT is more properly imagined as a dynamic set of approaches connecting research and policy processes." Moat and colleagues (Moat, Lavis & Abelson 2013) have further emphasized the research-policy dynamics in suggesting in essence to work backwards to research evidence when preparing evidence briefs for policy makers, that is, to start by supporting deliberation on the characteristics and influences related to the policy issue, As such in the policy context, as well as the health care delivery context, there is acknowledgement in how advances can be evidence *informed* [italics added] as opposed to evidence-*based*, and how other influences on policy can be acknowledged. Researchers studying public health decision making in the UK noted the tension between an evidence informed approach and people's deeply held desire for data and concepts that help simplify (rather than capture) messy realities, preference for 'concrete', 'hard' data (Smith, KE & Joyce 2012, p. 73). The challenge therefore is to find ways to engage practitioners, policy makers and health system planners in exploring not only data and evidence for what works, but also what is the nature of the

problem, why it occurs and how it might be addressed in specific contexts, often referred to as ‘fitness of purpose’ (Nutley, Walter & Davies 2007, p. 13).

Not only in medicine but also in population and public health there has been thinking about how “relevant knowledge is not being applied optimally” (Hobin et al. 2012, p. 105); and how, since action often precedes the science on interventions for complex public health issues, research is needed on the health effects of program and policy interventions already under way. Evidence that can inform interventions by being embedded in existing interventions is therefore seen as necessary (Green, LW et al. 2009). In this view of evidence generation, there is a tension between research that contributes to the knowledge base generally on the one hand and that which acknowledges local context and knowledge on the other (Van De Ven & Johnson 2006). To contribute to the interest in linking evidence to context, new approaches to knowledge gathering, such as scoping reviews (Arksey & O'Malley 2005) and to the process of synthesis, such as realist reviews (Pawson et al. 2005) have arisen. Such methods for linking and evaluating knowledge can assist the planning and application of knowledge and prompt the involvement of local users (Rowan et al. 2014). The integration of these various types of knowledge is the challenge, particularly in the context of large scale population health interventions, where outcomes are not immediately seen, rather they emerge over time (Davies et al. 2008).

Ottoson suggests that we use multiple lenses in consideration of knowledge to action theories: “the implementation lens sharpens a view of power, resources and relationships within theories. No matter how strong the what, how well timed its arrival, how supportive the context, or how receptive the stakeholders, sociopolitical factors can shape both the processes and outcomes of change” (2009, p. 16). The World Health Organization has added how inequities in setting research agendas and gender bias in health research contribute to the challenges of using research evidence alone to governmental policy and health system changes (Sen & Ostlin 2007; World Health Organization 2004, 2009). As such we need to see evidence building as a social and political process as well as a scientific process. As Cook (2009, p. 144) describes, “the manner in which knowledge and the knower is valued or challenged has been particularly central to research in women’s health”. Feminists have challenged the

positivist focus on what constitutes evidence and well as "the use, hierarchy and valuation of knowledge" (ibid.).

Indeed if knowledge translation is to be about the exchange and interpretation of knowledge that is needed to solve problems, rather than the application of evidence from research, then the need for forums where people can draw on many sources of knowledge and can "question their own pre-existing knowledge hierarchies" (Ward et al. 2012, p. 302) becomes important. The need for forums for sharing perspectives and identifying a range of sources of knowledge are highly relevant where there is polarization of how an issue is problematized and prioritized (Contandriopoulos 2011), as is the case in the context of substance use field in general and in the field's relationship to gender-based analysis and action on women's substance use. This need for expanded mechanisms for engaging with evidence, and the incorporation of gender-based analysis in the process, is a central theme of this thesis.

2.2.2 The substance use field and evidence

In 2006 an edited book was published with the compelling title: *Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It* (Miller, WR & Carroll). The flyleaf had the following quote:

> *While knowledge on substance abuse and addictions is expanding rapidly, clinical practice still lags behind. What if the field were able to begin anew, unfettered by the politics, programs and approaches that have emerged over the years? This state-of-the-art volume assembles leading experts to explore what treatment and prevention would look like if it were based on the best science available. (2006)*

The authors noted that very little scientific research had made its way into practice in the substance use field, and proceeded to summarize the research on biological, psychological and social factors associated with substance use and key intervention research. It signalled a positive direction in the substance use field toward evidence-based practice. A parallel development was taking place in the research-to-policy arena with the publication in 2003 of the groundbreaking book on alcohol policy entitled *Alcohol: No Ordinary Commodity* (Babor et al.), which proposed an international agenda for evidence-based alcohol policy.

This current study arises directly from the effort on the part of the Canadian Centre on Substance Abuse and Health Canada to move toward a more evidence-based approach to practice and policy in the substance use field with the development of the *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada*. The Framework was designed to "generate dialogue across jurisdictions, sectors and functions and to promote understanding of the issues by articulating a vision, principles and goals for national action . . . " (Canadian Centre on Substance Abuse Fall 2005, p. 10). Principle 4 of the framework specifically addressed the need for evidence, noting that this national action be "knowledge-based, evidence-informed and evaluated for results" (p. 12). The framework does not define 'knowledge-based', but implies that it means grounded in clinical, policy and indigenous knowledge, which would be a departure from the ideologically driven, narrow, one-size-fits-all stance of the 12-step movement[4], pervasively followed to that date. The term 'evidence-informed' reflects how little practice-based research was available, thus the need to be 'informed' by existing evidence, rather than 'evidence-based'. A priority on supportive infrastructure was identified in the Framework, including a research agenda (and knowledge exchange mechanisms), the research agenda to include:

> *fundamental and social scientific approaches; surveillance and monitoring, including surveys and ongoing data collection; evaluation, including policy and program evaluation on prevention, treatment, enforcement, and harm reduction interventions; and infrastructure (i.e. knowledge transfer, the entirety of supportive mechanisms needed to ensure relevant, timely, dynamic, and high quality research in the substance use and abuse field). (Canadian Centre on Substance Abuse 2005)*

While there was discussion of the evidence related to sex/gender differences in the experience of substance use and addictions in the course of the consultations leading up to the Framework, sex- and gender-based analysis and gender specific program approaches were not priorized. In spite of the ongoing generation of evidence for sex/gender differences in the prevalence, mechanisms, disease course, treatment entry and treatment outcome – this evidence has not been integrated in further national

[4] The 12 step movement includes Alcoholics Anonymous and all of the related groups such as Narcotics Anonymous and Gamblers Anonymous that are based on a set of 12 steps and 12 traditions that proscribe a method of recovery. In addition to the community based groups, many treatment programs ascribe(d) to this approach which in the treatment context is called the Minnesota model.

strategies. In the 2007 national alcohol strategy, only passing reference was made to the more serious health impacts of alcohol for girls' and women's health, and no gender-specific approaches were recommended in the many areas of action related to advertising, college campuses, bars and workplaces (National Alcohol Strategy Working Group April 2007). In the 2009 concurrent disorders report (Canadian Centre on Substance Abuse 2009) mention is made of the much higher prevalence of depression in women yet no implications for gendered approaches to practice for women affected by depression are discussed; there is but one sentence about the vulnerability of substance-using mothers and their children in inner cities who "are in desperate need of customized treatment settings and safer homes" (p. 8). Again in the national strategy related to prescription drug misuse (Canadian Centre on Substance Abuse 2013) while mention is made of the significantly higher rates of use of prescribed psychoactive medication in all categories except stimulants (i.e. pain medications, tranquillizers, diet pills) no recommendations for gender-specific approaches are identified, while culturally-appropriate strategies are mentioned repeatedly.

Consultation not resulting in research/practice/policy options or action can be seen as an example of how power relations need to be negotiated in bureaucratic or managerialist contexts (Nugus et al. 2012). As such, as created in this study, there is ongoing need for mechanisms for helping the leaders of national substance use strategies examine and consider gender-based analysis and options, in non-hierarchical processes.

2.2.3 Surfacing evidence related to sex, gender and substance use

This study is concerned with how multiple forms of evidence on women's substance use might be brought forth in a way that engages practitioners, policy-makers, community activists and others interested in women's health in examining, synthesizing and applying this evidence. Over the past three decades women's health researchers and activists been attempting to raise awareness of the evidence related to girls, women and substance use, to stress how women's substance use is an important health, economic, psychological and social problem in Canada.

In 1970, there were very few published studies on women and substance use. In the late 1970s, as part of the second wave women's movement, agencies and practices began to emerge that were focused on a feminist response to substance use and addictions in women. But it was not until after 20 years of practice and research that the first major Canadian collections on women and substance use were published: *Women's Use of Alcohol and Other Drugs in Canada* (Adrian, Eliany & Lundy 1996) and *The Hidden Majority: A Guidebook on Alcohol and Other Drugs in Canada* (Centre for Addiction and Mental Health 1996). Respectively, these books laid a foundation of knowledge about the history and epidemiology of substance use among women in Canada, and offered suggestions for approaches in response. In 2007, *Highs and Lows, Canadian Perspectives on Women and Substance Use* (Poole & Greaves) added to the existing evidence on women and substance use, as a collection of articles, interviews, narratives and guidelines reflecting the thought and action being applied in the decade between 1996 and 2006. The over ninety contributors to the *Highs and Lows* book came from many disciplines and professions, research and practice, and importantly from women with experience of substance use problems themselves. In that book we identified the challenge of providing appropriate responses (both prevention and treatment) to substance use issues, old and new, legal or illegal; and how defining and providing women-centred responses that empower and strengthen women are not always easy to embed in systems that are complex, traditional or male dominated. We spoke of how women-centred responses need to be embedded not only in care, but also in program design, research and policy development. How this might look, how we move forward to create positive, women-centred responses to girls' and women's substance use continues to constitute a major challenge in Canada.

There have been some advances in visibility and application of evidence on sex differences in the experience of health and illness overall. The Institute of Medicine asserted in 2001 that, "every cell is sexed", heralding a new era in US based science, of more attention to sex-related phenomena in health research. Simultaneously, health research funding bodies such as the Canadian Institutes of Health Research (CIHR) have implemented mechanisms to encourage researchers to design research, choose methods and carry out analyses that specifically take into account sex- *and* gender-related influences and factors. Bringing detail and guidance to health researchers are Canadian manuals addressing both sex- and gender-based analysis such as *Exploring*

Concepts of Gender and Health (2003a) and *Better Science with Sex and Gender: A primer for health research* (2007) *and Rising to the Challenge*: *Sex and gender-based analysis for health planning, policy and research in Canada* (2009) along with the proliferation of gender analysis policies in governments and health organizations across the world.

In the substance use field sex-based issues and differences have been clarified such as: metabolic differences, body shape and size issues, brain response characteristics such as dopamine receptivity, nicotine dependence trajectories and links with depression (Poole & Greaves 2007). These biological features of substance use need to be part of the evidence underlying prevention and treatment programming and policy design affecting girls and women. There are also important gendered influences on, and pathways to, substance use to be considered. For example, sexual and physical abuse, experienced more often by girls and women, are strongly related to problems with substance use (Logan et al. 2002). Gendered problems such as homelessness or poverty complicate treatment and recovery, and compromise girls' and women's health (Varcoe 2009). Gendered marketing practices employed by the alcohol and tobacco industries affect girls' and women's substance use (CASA 2003); and compounding the risks and pressures to use substances, is the societal stigma directed to women who use substances, which creates overwhelming barriers to care (Poole & Isaac 2001). In 2003 the National Institute for Health in US summarized this evidence on women gender differences in drug abuse by stating there are different biological mechanisms, different origins (risk factors, pathways and contexts of use) different courses, consequences and impacts of substance use as well as different access to and responses to treatment for girls and women (NIDA June 16, 2003). The *Highs and Lows* book (Poole & Greaves 2007) attempted to bring attention to these sex- and gender-based influences on women's substance use with presentation of research, as well as testimony from women and providers regarding their everyday experiences, and the (intended and unintended) consequences of programs and policies. And yet the field has been slow to respond to the evidence and thus mechanisms for facilitating action are direly needed.

Gender and substance use may indeed be seen as a "wicked problem" (Australian Government 2007), that is, multi-causal, socially complex and with no uni-dimensional solution and many failures at the policy level. As identified in the

discussion below, to achieve change on such issues, deep understanding of *context* and the *facilitation* of collaboration among many organizations is required.

2.3 Context

2.3.1 Expanding conceptions of knowledge users

Considerable attention has been paid in the knowledge translation field to the needs of individual practitioners and professional groups as recipients and implementers of evidence. For example: theories about cognition and motivation on the part of individual professionals are often cited (Grol et al. 2007; Hutchinson, A & Estabrooks 2009; Wensing, Bosch & Grol 2009); the need to address context-specific barriers to their involvement are addressed (Glasgow, Lichtenstein & Marcus 2003; Graham, Ian D & Logan 2004; Hanney 2004; Hemsley-Brown 2004; Legare 2009); and their social capital (Daniel, Schwier & McCalla 2003) and identity needs (Balatti & Falk 2002) have also been covered. In fact a whole 'science' - implementation science - has been advanced, which is concerned with the research-to-practice gap. The US National Institute of Health (NIH) has defined implementation as "the use of strategies to adopt and integrate evidence-based health interventions and change practice patterns within specific settings" (Fogarty International Center 2013) and research on implementation seeks to understand the level to which health interventions "can fit within real-world public health and clinical service systems". Overall the NIH focuses on understanding the behavior of healthcare professionals as a key variable in the implementation of evidence-based interventions.

As the lens on researcher-practitioner exchange widened to see not only health practitioners as the end users of evidence, but also decision of makers and policy makers in the health care and population health fields, again a narrow two-way exchange was initially applied, focussing on the evidence needs of the policy-oriented knowledge user. For example Chambers and colleagues (2011) talk about the need to help busy policy makers by preparing brief summaries of systematic reviews using formats such as Lavis' famous 25:3:1 formula (25 page evidence paper, 3 page executive summary and 1 page key points)(Lavis 2006, p.40). Now in descriptions of researcher to policy-oriented knowledge user exchange, the extent and strength of

linkages between researchers and policy makers are seen as strong predictors of effective knowledge translation (Conklin et al. 2013; Elliot & Popay 2000; Nutley, Walter & Davies 2007) especially ongoing dialogue and sustained connections which build trust (Boyko et al. 2012; Court & Young 2003; Sinfield et al. 2012). Less common has been documentation of knowledge translation strategies that involve multiple holders of different kinds of knowledge. However a former chairman with the World Health Organization described a process involving more stakeholders characterized as the "triangle that moves the mountain" (Wasi 2004, p. 106) where the mountain means a difficult or wicked problem, and the three points of the triangle are: relevant research knowledge, social movement or social learning, and political involvement. In general there is emerging agreement that further study is needed of the habits and research use of a "meso level set of service actors – those managing and shaping local service delivery organisations" as well as decision makers at the political level (Nutley, Walter & Davies 2007, pp. 7-8).

Complexity and feminist theorists have identified the importance of transdisciplinary involvement (Bammer 2005; Kirby, Greaves & Reid 2006). Bammer explains:

> *limited interaction and communication across different areas of application mean that, for example, researchers in environment are not exposed to developments in public health or business or security. Thus, there have been only low levels of intellectual cross-fertilization and learning, and limited exploitation of the significant synergies between approaches – This will involve bringing together and providing a clear identity and accepted place for a large "college" of peers, who can be both supportive and critical of each other's work - need systems thinking, participatory methods. (Bammer 2005, p.1)*

Transdisciplinary engagement entails both opportunities and challenges related to traversing disciplinary boundaries and paradigms. On the one hand, adherents of different paradigms may talk past each other, lacking common ground for productive dialogue (Dopson 2007, p. S73), on the other hand transdisciplinary involvement may also lead to the development of "a common language" (Rich 1978). In fact, Hulme and colleagues (2009) in describing the achievement of 'integrated' or 'trans-professional' knowledge in a collaboration process with multi-professional practitioners and health system planners in the UK, found that new ways of working could be found within 'undecided' reflective spaces. They discuss theories of 'third space' and 'hybridity' as

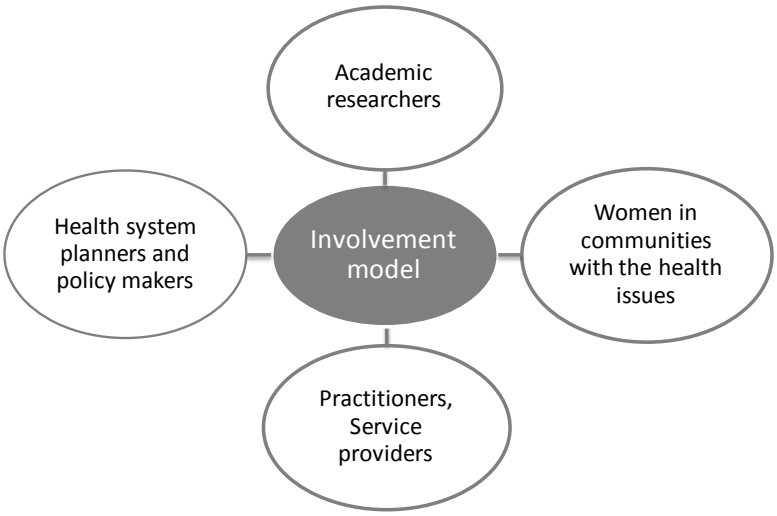
foundations for the broader application of transdisciplinary collaborations. In such processes the users are synthesizing, not only exchanging information; and the researcher is decentered in the multidimensional and multidirectional co-construction of knowledge by all involved (McWilliam, Carol L et al. 2009) Networks have also been proposed for achieving sustained dialogue and finding common ground among researchers, community partners and others interested in the application of frameworks for health system improvement (Best et al. 2003; Hutchinson, P, Poole & Reid March 2010). Transdisciplinary engagement has also been advocated to benefit from the strengths of both western science methods and traditional indigenous ways of knowing, without knowledge domination or assimilation, through the application of "two-eyed seeing" (Bartlett, Marshall & Marshall 2012; Hall in press; Martin 2012).

Indeed when a broader conceptualization of knowledge is embraced, and the involvement of community members, practitioners and policy makers and researchers is acknowledged "scientists must humbly engage people from diverse sectors in the research process so that knowledge systems can converge and be synthesized" (Hobin et al. 2012, p. 107). Concern with professional and sectoral boundaries between various users and generators of knowledge means we need new mechanisms for collective work such as networks, communities of practice or inquiry, epistemic communities (Haas 1992), and strategic research training programs organized around cluster based learning in community-research partnership clusters (Best, Terpstra & Moor 2004). A number of models of research use have tried to take into account the characteristics of the knowledge user and their practice or policy environment e.g. the revised Ottawa Model of Research Use (Graham & Logan 2004), but wide transdisciplinary engagement has not yet been well articulated.

Feminist researchers have suggested the merits of participatory action research as a methodology for changing health care practice through active involvement of those in a position to receive and offer services (Corbett, Francis & Chapman 2007). Feminist participatory action researchers explicitly put women's experience at the center of research processes, and apply the principles of inclusion, participation, action, social change and reflexivity throughout the research process (Frisby, Maguire & Reid 2009). Feminists have discussed and advocated for the involvement of users in research (at all stages not only knowledge translation), and for the recognition of a multiplicity of

voices. They have interrogated the positions of dualistic notion of the insider and outsider in such processes, and suggested instead how the involvement of multiple players can contribute to "sharpening each other (*uglolano*) and building each other (*uakana*)" (Lykes & Coquillon 2007). In such processes feminist researchers also "work the hypens"[5], (Fine 1994, p. 72) to counteract how we have "othered" the research subjects with whom we have worked, and further have not brought the multiplicity of ourselves into the process. Attention in the literature is emerging on how community based researchers are exploring a range of partnership models with community based organizations to inform knowledge translation approaches in a manner consistent with feminist reflexive practice.(Kothari & Armstrong 2011; Powell et al. 2013).

Figure 2.1 - BCCEWH Involvement Model



Over the past decade, researchers at the British Columbia Centre of Excellence for Women's Health (BCCEWH) have been facilitating multisectoral collaboration related to both research involvement and knowledge exchange on women's health issues (See Figure 1.1). This interest in multisectoral involvement arose from the feminist interest in bringing women with health concerns to the table, to integrate their lived experience on the topics being researched, to the formulation of questions, and to

[5] Working the hypen, means being reflexive about the researcher-research participant relationship, including coexploring the blurred boundaries between researchers and participants, how both mutually influence each other and research choices. also involves seeing the intersectionality of both researchers and research participants.

the interpretation and communication of findings. The BCCEWH's multisectoral focus also arose out of an interest in engaging health system planners and decision makers, not only practitioners and women with health concerns, into discussion of and action on women's health.

Maguire, Brydon-Miller and McIntyre in the introduction to their book on feminism, teaching and action research, see that:

> *. . . both knowledge and social action are created as the result of specific groups of people acting as subjects rather than objects of the inquiry process . . . research subjects must have a meaningful voice in identifying the problems to be explored. " (2004, p.xiv)*

In alignment with this view, the BCCEWH involvement model (Greaves & Ballem 2001) challenges the conceptualization of knowledge as derived from research alone, and advocates for researchers to be embedded in a multi-directional, interactive context that respects different sources of evidence, and supports reciprocal social learning.

2.3.2 Expanded, complex views of user context in the knowledge translation field

In 2002, members of the PARiHS team published on the "meaning of 'context'" (McCormack et al. 2002). They discussed in depth the importance of three elements of context, beginning with understanding the 'practice culture' (at the individual, team and organizational levels) and the ways in which it can constrain or support learning when doing knowledge translation. They described transformational leaders - those with a range of attributes and skills such as emotional intelligence, motivational and analytical skills - as the second central aspect of context. And thirdly they wrestled with the way in which accountability and effectiveness are being measured or evaluated, as it supports autonomy and relationships, in a complex interlay with the organizational culture. They concluded by saying that there were likely many more aspects of context than the original three the team had identified: such as systems of decision making, power differentials and the potential of the organization to innovate. In this they hint at widening the lens of knowledge translation from organizational contexts to more systemic and global ones.

Indeed in 2009, Kitson published on the need for health care systems change as fundamentally linked to knowledge translation, and the importance of purposively integrating systems theory with knowledge translation theories to enable speedier uptake of knowledge (Kitson 2009b). She critiqued the traditional knowledge translation theories for their linear propositions and tenets related to knowledge as something that can be managed in a logical and staged process. Drawing from complexity theory and its applicants, such as organizational learning expert Peter Senge, she postulated that "the health care system is best viewed as a complex, interactive, organic entity where experimentation, experiential learning and reflection are central to creating a culture of innovation, improvement and consequently effectiveness" (Kitson 2009b, p.218). This paper challenged the ideas put forth by the prevailing knowledge translation experts that the process of knowledge translation could be planned and coordinated in a contained manner, and proposed instead that it be viewed as another type of multilevel, and complex innovation process. Van de Ven and colleagues had posited (1999) that such elements as a coalescence of internal and external factors, setbacks and mistakes, and a staff emotional roller coaster characterize such processes. More recently Kitson has envisaged a complex view of knowledge adoption "contingent upon learning styles and culture, levels of autonomy and support in terms of resource injection, and new ways of defining boundaries around power, groups, communication and action" (2009b, p. 223). She goes on to discuss how facilitation of such processes had not been studied so that "what is still left unanswered is whether external or internal change agents or facilitators can enhance or impede these emerging processes" (2009b, p. 223).

Others such as Grol and colleagues (2007) have advocated for using transdisciplinary theoretical perspectives to guide the approach to knowledge translation depending on the nature of the evidence to be conveyed and the context in which it is applied. They considered theories focussed on individuals, such as motivational theories, theories related to social interaction such as social learning theory, theories related to organizational context such as theories of integrated care, and theories related to the political and economic context as they help us understand implementation of innovations and change. Interestingly they make mention of stages of change theory as having little evidence of effectiveness, and yet having popular appeal. Stages of change theory has been commonly used in the substance use field, and has been difficult to

unseat, as feminists have found when advocating for more effective approaches with pregnant women with substance use problems. Such narrow theoretical frameworks have had significant influence in practitioner contexts.

In a study undertaken by Court and Young, which examined fifty cases of knowledge translation in developing countries, context emerged as the most important domain affecting the degree to which research has an impact on policy (Court & Young 2003). Key contextual issues were prevailing narratives and discourse among policy-makers; the extent of demand for new ideas (by policy-makers and society more generally); and the degree of political contestation. Political resistance often hindered change, despite the existence of clear evidence, and bureaucratic factors often distorted public policies during implementation. The study raised many questions about defining and influencing context to improve research to policy-making and practice translation.

Jacobsen and colleagues from the Centre for Addiction and Mental Health in Toronto attempted to develop a framework for knowledge translation that is primarily built on understanding user context (Jacobson, Butterill & Goering 2003). They see it as important for researchers to develop a familiarity with relevant user groups by considering questions that illuminate the generic characteristics of user groups that are important to knowledge translation such as:

- In what formal (legislation or bureaucracy) or informal structures is the user group embedded and how does it fit with the prevailing ideology in these structures?
- What is the political climate surrounding the user group?
- To whom is the user group accountable?
- How institutionalized is the user group?
- What actions are available to the user group?
- What is the user group's pace of work?
- Has the user group demonstrated an ability to learn?
- What resources does the user group devote to knowledge translation? (Jacobson, Butterill & Goering 2003, p. 96)

With these, and many other questions, they are advocating that researchers use their research skills to understand user context, both before and during the process of knowledge translation.

This doctoral work is concerned with providing opportunities for people from multiple contexts, to collectively discover and enact much wider sources of knowledge and possibilities for action together. Kitson speaks of this in relation to guideline implementation

> *Successful knowledge translation therefore becomes more reliant on processes that create 'shared meaning' and on mechanisms, such as the establishment of cross functional teams, co-location and the use of various shared methodologies, such as nominal group technique or consensus building. In addition, processes, such as communities of practice and learning collaboratives enable diverse, heterogeneous groups to be able to share their different perspectives in order to come to a mutually acceptable view of what works and what matters for each group (Kitson 2009a, p. 136).*

Huzir and colleagues (Huzair et al. 2013) affirm this focus on collaborative mechanisms in the South African context, boldly noting that uptake of research is not the goal of knowledge translation, that instead knowledge synthesis and exchange, including knowledge of sociopolitical influences at both the government and community levels will more effectively enable realization of goals on complex health issues.

Often in the knowledge translation research field there is discussion of barriers to research use in the knowledge users' context. Barriers such as knowledge user time, professional affiliation, agency interests, ideological environment are mentioned (Legare 2009; Thompson, DS et al. 2008). However in a study within the National Health Services in the UK, Checkland and colleagues found that the barriers reported by practitioners as preventing implementation were less important than the context and the underlying social relations that give rise to them (Checkland, Harrison & Marshall Apr2007). They spoke of the importance of supporting collective sensemaking with intermediary forums. Studies of barriers are seen as limited by the view of research use as an individualized process over a collective one.

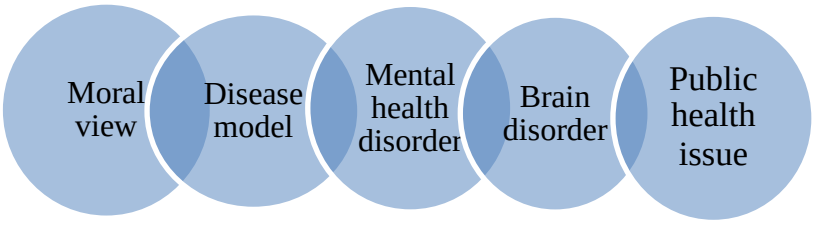
Feminists are often viewed as experts in conceptualization of context. One of the key critiques of research made by feminists is the hierarchical deductive approach to knowledge building, which is seen as laden with power and treating knowledge as

something to be discovered rather than created (Hesse-Biber 2007). Feminists have long discussed knowledge building as a relational process that requires participatory reflexive approaches where the researcher is in the same critical plane as the participants (See for example, Cancian 1992; Harding 1987; Lather 1991), with a commitment to address power and knowledge exchange along the entire research process. It is seen by feminists that in attending to context within the research process that at the end, new kinds of questions are raised, subjugated knowledge is unearthed and issues of race, class, sexuality, nationality and gender are taken into account (Hesse-Biber 2007, p.16). In feminist research contexts, gender is problematized, the absence of women in research generation is addressed, and the translation through activist work in communities is honoured (Frisby, Maguire & Reid 2009; Hesse-Biber & Leckenby 2004; Kirby, SL, Greaves & Reid 2006).

2.3.3 Acknowledging the substance use field context

A range of views of substance use and addiction were/and continue to be in operation in Canada, which affect openness to use of evidence, collaborative examination of evidence and gender-based analysis. While newer views of addiction and how we should respond to it have been advanced, the moral view of addiction and the more traditional disease models also remain in operation. Engagement with these ideologies and discourses is both unavoidable and critical when examining evidence on gender and substance use, and considering how to make it visible and acted upon.

Figure 2.2 - Five mainstream views of addiction in the current discourse



The moral view of substance use and addiction (first circle) is held by Canada's current Prime Minister (Galloway October 5, 2007). Those holding this view perceive a hierarchy of drugs; and focus on illicit drugs, as most dangerous. In this view, illicit

drug use is seen as an individual pathology: drug users are deviants, compelled to use drugs by dealers and by their own weakness, and individually responsible for their failure to abstain. In this view all drug users require, and are responsible for getting treatment; and abstinence is the only acceptable goal of that treatment. Stepped approaches to recovery such as harm reduction initiatives are seen as enabling drug use, and thus are not supported. People who sell (and use) drugs are seen as criminals who need to be jailed. In the moral view, the focus is on male drug users, as males are the higher users of illicit drugs. Women drug users, when mentioned, are viewed very negatively (Boyd 2004; Murphy & Rosenbaum 1999).

Those who adhere to the disease model (second circle) see all substances (not only illicit ones) as potentially of concern. For example the American Medical Association's stance on problematic alcohol use (and the definition adopted by Alcoholic Anonymous in much of their literature) is as follows: "Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial" (JAMA, 1992). More compassion for the substance user is evident in this view, particularly through understanding the personal barriers to acknowledging substance use problems and accessing and succeeding at treatment.

From the disease model, further efforts to medicalize substance use problems, in this case as mental health disorders (circle 3) have been advanced (Canadian Centre on Substance Abuse 2009; Kirby, MJL & Keon May 2006); and initiatives in all Canadian provinces have been undertaken to merge the addictions and mental health responses. This has been done in a largely gender-blind manner (Greaves Spring 2006; Greaves & Poole October 2007). More recently the neurobiological research funded by the National Institute on Drug Abuse in the US (National Institute on Drug Abuse April 2007) has prompted a further move along the medicalization continuum (circle 4), to where the American Society of Addiction Medicine has declared addiction a "primary, chronic disease of brain reward, motivation, memory and related circuitry" (American Society of Addiction Medicine 2010). Such developments by powerful scientific forces

make it difficult to open up space that advances critical and public health oriented views of substance use and addiction.

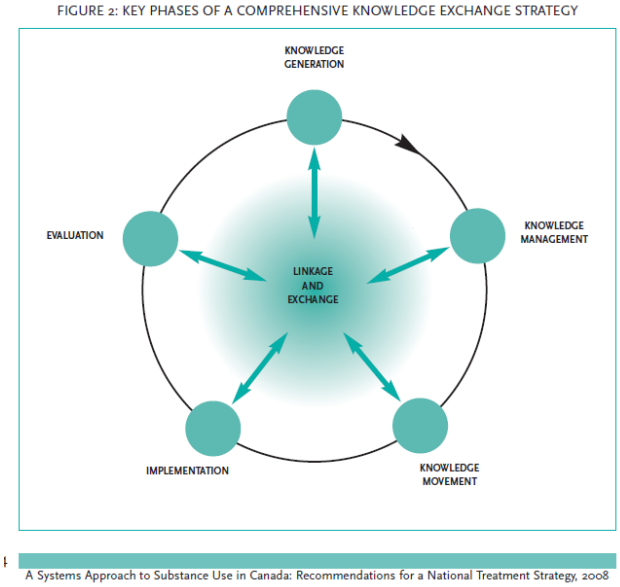
In the public health view (circle 5), attention is brought to the how determinants of health such as gender, violence, income, genetics, social support and health services all combine to affect the health and substance use of individuals and communities. In a public health view, there is also attention to policy to minimize harms on the community and societal levels, placing responsibility for health beyond the individual (Pauly 2008). Some transdisciplinary perspectives are emerging that link public health and brain disorder views of addiction (Greaves, Poole & Boyle 2015; Mate 2008) Many of the participants in this study of knowledge translation using a community of practice that examines women's substance use, might personally ascribe to a public health view of substance use and addiction, but be faced with navigating a system where all five views influence policy and practice.

In Canada there has been some advancement of a critical feminist view, notably in the publications of Dr. Susan Boyd, who sees drug use as shaped by "the social and cultural environment, as well as by drug laws and by social service, medical and non-government policy" (Boyd 2004, p. 12). She describes women's and men's use of substances as "mediated by race, class and gender in conjunction with history, culture, politics and the legal and sociological environment". A gender lens applied in this view highlights how "women are socially controlled in ways that differ from men, and how the regulation of women centers on reproduction, mothering, double standards of morality, social and legal subordination" (2004, p. 13).

The National Framework document (Canadian Centre on Substance Abuse Fall 2005) described issues and priorities for the substance use field, and stressed the need for creating the conditions for collaboration among "stakeholders, researchers, experts and jurisdictions" (Canadian Centre on Substance Abuse Fall 2005, p. 19) but was not specific about the knowledge exchange mechanisms that would be required. In the later National Treatment Strategy document (National Treatment Strategy Working Group October 2008) this was made more explicit. In that document a "comprehensive strategy to facilitate the development of an improved knowledge exchange infrastructure" (p. 23) was identified. In fact it described a model of "two-way movement of knowledge

between those who produce it and those who use it (e.g., the linking, through informal and formal networks, of community-based research and research-focused training)" (p. 23). CCSA and the key informants comprising a national working group to develop the National Treatment Strategy saw this model of linkage and exchange between knowledge producers and knowledge as linking participants with different knowledge sets and different roles in the production, management and use of knowledge. See Figure 2.3.

Figure 2.3 – Key Phases of a Knowledge Exchange Strategy from *A Systems Approach to Substance Use in Canada*



This national treatment strategy working group recognized that such a knowledge exchange infrastructure needed to

- *be flexible, credible and responsive to a broad range of stakeholders in a variety of contexts*
- *be able to synthesize knowledge and provide guidance for policy and practice*
- *be able to identify and employ effective mechanisms to introduce new knowledge and to support and reinforce its use*
- *engage those involved in research and implementation in partnerships to define questions and seek answers that advance evidence-informed practice (to ensure that a population-informed approach is used, these partnerships must include representation from the full diversity of people who experience substance use problems, as well as affected family, friends and other carers)*
- *ensure that researchers and service providers are engaged in bidirectional knowledge exchange (October 2008, p. 23)*

While the key informants developing the knowledge translation portion of the national treatment strategy document recognized the need for multisectoral involvement, they saw the process as bi-directional not multidirectional. And while they saw the need to "collect and synthesize" (October 2008, p. 25) knowledge, they referred to synthesis of existing knowledge only, and recommended a national knowledge exchange network as the key mechanism that would support such linkages and exchange.

This explicit recommendation for linking and applying evidence to practice and policy was a first for the substance use field in Canada. It created an opening for the implementation of this study, while the field's competing paradigms and overall gender blindness underlines the need for new mechanisms for knowledge translation in the field.

In 2005 Bammer noted how researchers, funders, and research end-users were increasingly appreciating that new research skills must be developed if human societies are to be more effective in tackling the complex problems that confront us and in sustaining the sort of world we wish to live in. Researchers must collaborate and integrate across traditional boundaries. They must bring together academic disciplines and become more involved in the implementation of research in policy, product, and action (Bammer 2005, p. 1). She issued a call to action to work in new ways to address complex problems based on systems thinking, participatory methods, and knowledge management which: appreciates that there are many forms of knowledge and ways of knowing (diverse epistemologies); provides enhanced methods for accessing knowledge, realizing that both volume and diversity are current barriers, and involves developing better understanding of how policy is made, how business operates, how activism succeeds, and how action is and can be influenced by evidence.

2.4 Facilitation

Facilitation is the third aspect of the PARiHS knowledge translation schemata and a focus of this study. It has been described as key to engagement with evidence and understanding of context (Harvey et al. 2002; Kitson 2009a). In fact, Clavier and

colleagues have recently described knowledge translation as “the skilled crafting of cognitive, strategic and logistic practices that interweave the values, interests and ideas of each partner so as to contribute to new problematisations of participatory research and the research issue under scrutiny (Clavier et al. 2012, p. 802).

Over time a number of researchers have described the levels or stages of knowledge exchange, requiring management or facilitation. For example, Landry (2001) describes a ladder of stages from transmission to application. Glasziou and Haynes (2005) frame the process of research use by practitioners as following a 7 stage pipeline model: 1) aware of the findings, 2) accept the finding, 3) view the findings as locally applicable 4) view the findings as locally doable , 5) act on the findings, 6) adopt the research findings and 7) adhere to the research findings. Palmer and Kramlich (2011) describe the stages as reflective inquiry, knowledge seeking/generation, integration, implementation, evaluation, mentoring, and additional reflective inquiry (p.33). Best and colleagues (2004) stress the importance of complex, systems-level views, over a focus on individual adoption, and see the need to understand system antecedents for innovation, and system readiness for innovation, as well as linkages between researchers and community. However the process is conceptualized, there is increasing attention to the need for and improvement of collaborative processes, including “ensuring that appropriate researchers and sectoral representatives are included, that their world-views are made explicit, that their interests are accommodated, that different strengths are harnessed, that communication mechanisms are strong, and that conflicts are appropriately mediated” (Bammer 2005, p.2).

2.4.1 Interactivity, linkages, dialogic deliberation and synthesis

Indeed more attention has now been brought to the importance of interactivity in knowledge translation (Beyer 1997; Cross & Sproull November 2006; Innvaer et al. 2002); and the need for researchers to engage in new ways with end users, in longer term relationships (Bowen, Martens & The *Need to Know* Team 2005; Canadian Health Services Research Foundation December 2003). New roles such as knowledge brokers have emerged to promote and facilitate knowledge exchange and co-learning activities among the many parties involved in knowledge translation (Conklin et al. 2013)

Researchers from a range of perspectives have commented on the importance of linkages and the need for structures that support them. Working in the area of health promotion as complexity theorists, Best and colleagues proposed "investing in **networks** that promote, support, and sustain ongoing dialogue and sharing of experience; finding common ground in an approach to community partnering; and gaining consensus on the proposed integrating framework" (Best et al. 2003, p.168) as a way of closing the gap between health promotion research and practice.

Dopson and Fitzgerald (2005) have proposed that **local communities of practice** can play a critical social role in the diffusion of evidence and innovation, and that the boundaries between these communities affect the way evidence and knowledge are perceived and interpreted. They see knowledge as interpretable, with the decision to use new knowledge as a social and political process. With technological advances, the practice of transnational communities of practice related to health policy have also been studied as mechanisms for enhancing "exchange and co-production of knowledge" (Bertone et al. 2013, p. 5) across borders.

In women's health, **participatory action research** (PAR) has been advanced as a useful approach to underpin knowledge translation processes, in a rural community context (Campbell, B 2010) for examining nursing practice (Corbett, Francis & Chapman 2007) in/with indigenous communities (Fornssler et al. 2013; Smylie, Kaplan-Myrth & McShane 2009) in primary care groups (Thomas, P et al. 2005) and in health policy development (Themba & Minkler 2003).

The focus on supporting interactivity has extended even to the micro level to the role of **conversation** in collective sensemaking and co-learning (Jordan et al. 2009) – conversation both in health care settings and at kitchen tables in Aboriginal communities (Hopkins 2012)

All of these forums – networks, communities of practice, participatory action research, engaged conversations - support the processes of dialogue, synthesis, co-construction of knowledge, co-learning, reflection, integration, and collaboration (Ebener et al. 2006; Ginsburg & Gorostiaga 2006; Landry et al. 2006; Lavis et al. 2006). They involve a dialogical learning approach which draws on the work of Freire in adult

education (Freire 2006), and Habermas's concept of egalitarian dialogue and communicative action (Goode 2005; Morrow & Torres 2002) as well as dialogic feminism (Bickford 1996; Merrill 2005). In forums involving dialogic deliberation, participants potentially construct a concept of self and other, a sense of community and agency (in this case as agents of knowledge exchange, synthesis and application) (Broner et al. 2001; Kim, J & Kim 2008).

2.4.2 Situated learning in communities of practice

Wenger has described communities of practice as "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger, McDermott & Snyder 2002, p. 4). Estabrooks and colleagues (2006) in their guide to knowledge translation theory point to social learning theory, such as that advanced by Wenger (1998) as a way forth in understanding how service providers produce and make use of knowledge in negotiations with others as they go about their daily practice (p. 33). Others have also seen communities of practice (CoPs) as important new structures for achieving knowledge translation ends (CHSRF December 2006) and "an optimal way of managing the conceptual, instrumental, and strategic use of knowledge" (Palmer & Kramlich 2011, p. 32). Communities of practice are viewed as a pragmatic or conceptual framework, useful for a knowledge translation model (Cox 2005; Hart & Wolff 2006) particularly for examining social learning and the situated social construction of meaning (Baek & Barab 2005, p.163).

There is a significant amount of literature on the use of communities of practice in many sectors, including the health sector (Bentley, Browman & Poole 2010; Greenfield et al. 2007; Li et al. 2009b; Ranmuthugala et al. 2011). CoPs in the virtual context have often been implemented and analysed (See for example, Baek & Barab 2005; Henri & Pudelko 2003; Johnson, CM 2001; Sharratt & Usoro 2003). While four characteristics have been identified in CoPs in the health sector - social interaction among members, knowledge sharing, knowledge creation, and identity building (Li et al. 2009b) - these authors found that these elements have not been found to be consistently present in all CoPs and much remains to be studied as to facilitation, including handling of power relations.

Key concepts related to communities of practice as outlined by Wenger (Lave & Wenger 1991; Wenger 1998, 2004; Wenger, McDermott & Snyder 2002), are valuable to the design and implementation of locations for co-learning in the service of knowledge translation. The three core elements of a community of practice - domain, practice, and community – are illustrative of CoPs as social learning locations relevant to knowledge translation. The **domain** of a community of practice refers to the shared concern or set of problems that members share, that which prompts them to come together, and which organizes the community's knowledge. In Wenger's research the CoP participants had a trade (e.g. midwives) or an organizational affiliation in common. Others have fostered communities of practice with multi disciplinary (Li et al. 2009b), interagency (Lathlean & Le May 2002) and distributed (Daniel, Schwier & McCalla 2003) involvement. Even national platforms for collaboration in communities of practice are being nurtured (Bentley, Browman & Poole 2010). In the case of this study, the common territory is work in the substance use field and specifically on one or more priorities of the National Framework. The community of practice in this case was not formed 'serendipitously' when members recognize a common domain (a passion for bringing gender specific approaches related to women's substance use into their work). Instead the opportunity was presented to meet together in a virtual community to explore the evidence for gender-based approaches.

One aspect of this study is to explore the value of employing a community of practice model for supporting learning. The role of apprenticeship was key to Wenger's thinking: that through participating in a community, novices can learn through collaboration with others and by working alongside more experienced members (Barab, MaKinster & Scheckler 2003, p. 238). Similar to an apprenticeship, ideally participants interested in sex and gender differences as they exist in the substance use field within a community of practice could have the opportunity to work with those experienced in gender and diversity based analysis (SGDBA), the experience of doing SGDBA collectively in the community, and then gradually begin to adopt it in their daily work. This social view of learning treats learning as a process of constructing practice, meaning, and identity within a community (Handley et al. 2006; Lave & Wenger 1991).

In such cases where the community is designed rather than naturally emergent, it is important to pay attention to the development of the elements of **practice** that bring coherence to a community, such as mutual engagement, including respect for different forms of competence, a shared repertoire as a resource for the negotiation of meaning (Wenger, McDermott & Snyder 2002). Thompson (2005, p. 151) discusses the "delicate conjunction between learning, identity and even motivation" within CoPs and the role of organizations in seeding versus controlling structures that encourage members to make their ideas visible and in which epistemic components are carefully considered and fostered.

Members of a community of practice learn from and with each other. "Through its practice–its concepts, symbols, and analytic methods– the community operates as a living curriculum" according to Wenger and colleagues (2002, p. 38). Communities of practice value both tacit and explicit forms of knowledge. They recognize the need to complement individuals' intuitions, perceptions, and vernacular knowledge with the more explicit concepts of an evidence-based paradigm. Communities of practice are social learning structures: they are open venues of exploration, "where it is safe to speak the truth and ask hard questions" (p. 37) and where members "develop the habit of consulting each other for help" (p. 84).

Another structural element of a community of practice is **community.** It denotes a set of interpersonal relationships arising out of people's mutual engagement in learning through practice. Participation relates to "a sense of belonging to the community, and it is both a condition under which learning takes place as well as a constitutive element of the content of the learning" (Stehlik 2005, pp. 138-139). The connectivity, together with the community's negotiated meanings and shared expertise provides the cohesion and can promote learning and action. An aspect of this study is to consider how the short term nature of the study's community, as well as it's distributed and multisectoral nature affects participation, sense of community and self efficacy on the part of participants (Handley, p. 664). Of particular interest is its transformative potential - in sharing and building on what each other knows, and the way that participants see effective practices can be shifted (Buysse, Sparkman & Wesley 2003, p.265). Shifts in identity are highly relevant.

Wenger's 1998 book treats communities of practice as the informal relations and understandings that develop in mutual engagement on an appropriated joint enterprise, but his focus is the impact on individual identity. In learning about gender and substance use it is not just about developing one's knowledge and practice, it also involves a process of understanding who participants might be as agents of change. Given the multiple paradigms in play as the nature of addictions, resisting moralistic paradigms and advocating for gender transformative ones comes into play. In his book Moral Discourse in a Pluralistic World, Daniel Vokey (2001) argues that it is possible for people from very different religious, political, philosophical, and cultural traditions to talk productively about the issues that divide them. Using the term moral discourse to refer to the processes involved in assessing moral points of view, Vokey shows how evaluating the relative merits of rival paradigms is a crucial step in the search for consensus.

As such, the community of practice model will be utilized in this study as a location where facilitation of learning can take place, with diverse participants on complex, gendered health issues, in a context with moral as well as scientific discourses in play. CoPs are relevant as they can engage participants with appreciation of or expertise in different forms of knowledge; support collective examination of knowledge in ways that break down isolation and promote dialogic deliberation; and help with the consideration of "how activism succeeds, and how action is and can be influenced by evidence" (Bammer 2005, p.).

In the initial conceptualization and design of the online community, consciousness raising, feminist particpatory action and community of practice models as nonhierarchical, social learning approaches to fostering dialogue and action served as guiding models. As the study progressed, the need to consciously consider how to support dialogue, set climate and select content, for and with, the community participants in the online environment emerged (Garrison & Vaughan 2007). Thus the community of inquiry model where the concepts of social presence, cognitive presence and teaching presence are introduced and a practical inquiry model is employed, influenced the facilitation model for the the community (Garrison & Arbaugh 2007, Garrison & Vaughan 2007). An increasing understanding of how to link content and

pedagogy in online knowledge translation initiatives, in order to foster learner self efficacy became evident.

2.4.3 Leadership, brokerage, engaged scholarship

Beyond the need for the study of overall locations for knowledge translation practice such as communities of practice, is the need to understand the role of those that lead or facilitate them, who manage the integrated, interactive process (Cherney et al. 2013; Chunharas 2006; Flood 2010; Sinfield et al. 2012)

> *Roles, such as knowledge brokers (roles positioned between producers and users of knowledge in order to ease the spread of the new innovations) and boundary spanners (roles which can network effectively in order to understand the culture of an organisation), can be used to enable the flow of knowledge between different groups. These roles are recommended when it is clear that multiple interpretations are required before a shared understanding of the impact of the new knowledge (guideline) can be assessed against the old (current) knowledge. (Kitson 2009a, p. 136)*

While not an original thrust of the research, in the course of the facilitation and analysis of the study's community of practice, this became a line of inquiry. Green and colleagues compare the brokers, boundary leaders and linking agents advocated in the knowledge translation field to Galdwell's description in the Tipping Point of connectors, mavens[6], and salesmen (Green LW et al. 2009, p. 163). Nutley and her UK colleagues (2007) pick up and expand upon the idea of the researcher as spanner and interpreter of context, to discuss how researchers can take a stance outside the prevailing paradigm, "using their work to problematise established frameworks and ways of thinking" (p12). Further, others have said that such boundary spanners need to be " fluent in both activist and scholarly cultures" (Sudbury & Okazawa-Rey 2009, p. 8) with the potential to see teaching in learning communities as concerned with fostering oppositional work. As such this research will discuss facilitating and teaching reflexivity in the feminist tradition as a vehicle for reflection about and action on inequities (Bondi 2009; Lykes & Coquillon 2007).

Weiner speaks of how in the intersection of critical action research and third wave feminism, the separation of teaching and research becomes blurred, and that:

[6] Maven is a term used by Gladwell to mean expert who likes to pass on knowledge, and which Green discusses as relevant to the concept of early adopter.

> the boundaries for feminist action research at the turn of the twenty first century have broadened out. Feminist action research recognizes and works with the evident possibility that individuals can be creative and imaginative, even when confronted by oppressive regimes and cultures of regulation, and that the role of feminist action is to move beyond the resistant and defensive. (Weiner 2004, p.640)

In the course of reviewing the literature on knowledge translation, I came across the work of Van de Ven and Johnson (2006) who use the term "engaged scholarship". They see the need for "collaborative inquiry in which academics and practitioners leverage their different perspectives and competencies to coproduce knowledge about a complex problem or phenomenon that exists under conditions of uncertainty" (p. 803). Their endorsement, beyond that of feminists, of 'engaged scholars' seemed a hopeful sign in the field of knowledge translation, and this concept will be explored as facilitation of communities of practice/inquiry is further discussed in chapters four and five.

2.5 Summary

As discussed in the introduction, a driver of this study was to understand knowledge translation as it is currently being studied and enacted, as a foundation for situating and improving knowledge translation practice on complex women's health issues, such as women's substance use. The literature on knowledge translation is rich and complicated. Over the past two decades, the literature has described multiple shifts in the scope of knowledge translation: from a one way process of bringing evidence into practice and policy, that is, rather technicist implementation practice, to multidirectional processes, involving multi-holders of multi forms of knowledge. These trends and developments in knowledge translation have been described using the three core elements of the PARiHS framework – evidence, context and facilitation.

Much of the early literature focussed on one form of knowledge, research **evidenc**e, as a commodity to be to be applied directly to practice and policy. Over time, many complexities emerged related to this research-to-action trajectory. The conceptual as well instrumental use of research, the sociopolitical context of the application of evidence, the emergent nature of knowledge(s) through interactivity, and the triaging

influence of prior knowledge and assumptions have all been identified as confounders to a narrow and linear evidence-to practice path. Many of these confounders can be seen to be in play in the substance use field, as it aims to move from ideologically driven approaches to prevention, harm reduction and treatment, to more evidence-informed ones. The challenge of bringing a sex and gender analysis to this work in the substance use field, which can be seen to have operated in a largely gender-blind mode, underlines the importance of creating knowledge translation mechanisms which support reflexive processes where multiple forms of knowledge can be considered and interpreted.

Expanding our notions of the users of evidence and of their **context**s has been another important trend in knowledge translation practice. Knowledge translation researchers first considered bidirectional exchange between researchers and health care practitioners with a focus on individual barriers to the application of research to practice. Now the involvement of multiple knowledge users including researchers, practitioners, policy analysts, decision makers, community advocates and people with the health concerns, as well as their diverse contexts, perspectives and opportunities are considered relevant, and where researchers are decentered. The organizational and sociopolitical contexts of all these players, not only their individual learning needs are included as important elements to be weighed and addressed. Transdisciplinary processes of exchange and action have been promoted as important for accommodating these complexities. Feminist participatory action research processes with their focus on inclusion, participation, action, change and reflexivity have the potential to offer much to such processes.

However, in spite of the potential for drawing on participatory, reflexive processes advanced by feminists, critical feminist views and practices have been marginalized in the substance use field. The context of the substance use field can be described as politicized with multiple views of addiction in operation, and the institutionalization of particular ideas creating a resistive or counteractive impact on the inclusion of gender-based analysis and action. Such an evolving context calls for collective learning forums such as communities of practice.

Indeed the literature calls for a focus on **facilitation** and highlights the need to find processes, to allow for the engagement of knowledge users in learning about,

synthesizing and applying the evidence to their specific context yet in a way that is linked to system wide efforts. Communities of practice have been described in the knowledge translation literature as offering an ideal context for integration, interactivity, synthesis and action on knowledge. The community of inquiry model offers an additional constructivist learning lens to the facilitation process. Given that knowledge users will have diverse agendas, time frames, cultures, and sources of knowledge they consider legitimate, the need for facilitating intersectoral or interdisciplinary learning processes becomes critical. Beyond countering isolation or managing differences, the facilitation role becomes one of promoting participation, preventing oversimplication and supporting whole systems view, employing a range of strategic and critically reflective practices.

This chapter has identified developments in the literature on knowledge translation - particularly that naming of knowledge translation as an “impoverished” metaphor relative to a framing of the process as one of knowledge generation via dialogue among multiple users (Greenhalgh 2010). The next chapters will describe the design, implementation and methods for studying a virtual community of inquiry that addresses the identified, generative, dialogic requirements. The community that is studied in this thesis involves collective, participatory online engagement with evidence related to women’s health and substance to support co-learning on these complex, gendered health issues; and uses evidence from the fields of feminist theory and practice, situated and transformative learning theory and practice, and technologically supported learning to achieve this end.

Chapter 3 – Methods that integrate paradigms

> *"Research processes involve "choice of the problem, choice of the paradigm to guide the problem, choice of theoretical framework, choice of major data-gathering and data-analytic methods, choice of context . . ." (Lincoln, Lynham & Guba 2000, p. 169).*

The previous chapter set the context for the study in the current practice of knowledge translation in Canada, and the specific evidentiary and activist challenges related to knowledge translation on marginalized women's health issues, such as women's substance use. The research question that frames the inquiry suggests a particular methodological approach, which is explored in this chapter. This chapter describes the methodological underpinnings of the study of a virtual community designed to serve as an innovative model for knowledge translation on marginalized women's health. It describes and emphasizes the theoretical and practical utility of the multiple paradigms of inquiry which were drawn upon. It outlines the detailed methods employed for the virtual infrastructure, participant recruitment, data collection, and data analysis. It offers the limitations inherent in a single case study approach. It concludes by situating the study and its significance in the manifestations of action research identified by Bradbury and Reason (2003).

3.1 The focus of the inquiry

The focus of this inquiry (the choice of the problem) is inclusive virtual locations which support, or fail to support:

- the examination of research and other forms of knowledge,
- collective discussion and synthesis of this knowledge, and
- collective consideration of how to apply such synthesized knowledge to promote equity in health care delivery.

Engagement, inclusivity (across geography, sector, race and other dimensions), co-learning, and reflexivity are key aspects to this inquiry. Also central to the inquiry is the application of a gender lens. Virtual locations are considered in light of how they may provide, or fail to provide, the conditions for inquiry into: the social conditions of diverse women's lives, gendered power relations that impede equitable access to

services, and action that promotes social change. The substance use field is the context of this study, and virtual communities are examined as potential locations for the substance use field to apply gender- and diversity-based analysis, in order to improve clinical practice and policy affecting girls' and women's health.

3.2 The paradigms drawn upon

To address this research focus, participatory and critical research paradigms (Kuhn 1996) are drawn upon. These research paradigms intersect with epistemological and pedagogical stances that are grounded in feminist theory and practice.

3.2.1 Participatory inquiry

Famous experts in qualitative research methods, Heron and Reason (1997) state that a participatory world view has underpinned their work in cooperative inquiry and other participative forms of research over several decades. They describe a participatory view as both an epistemological and a political principle. They see the participative mind as one that articulates reality within a paradigm, articulates the paradigm itself and can in principle reach out to the wider context of that paradigm to reframe it (p. 275). In such a worldview, in interrelation with nature and with others, we are continuously creating reality: in participating in it we are both moulding it and encountering it (p. 278).

There is a political aspect to the participatory paradigm. In this study people are being brought together to have the opportunity to interact, to share interpretations and to shape interpretations about gender. This opportunity is important as gender issues have been marginalized in the substance use field: most practitioners and decision makers have not had/taken the opportunity to experience, interpret or voice a gendered view. It is this experience and interpretation of approaches to their work that take gender into account, which is of interest in this study. In participatory inquiry contexts, participants have the opportunity to learn more about their commonalities of experience and perspective. Participants in this study are unlikely to have previously known each other, have only their work in the substance use field and their interest in considering gender

in common. Creating a space for construction and production of situated knowledge is the goal. It is a process of setting up - as Genat (2009) has described - “a space of interaction where emergent meaning can be examined, contested, debated, reviewed, recorded and constructed” (p. 107). In this social context, where representations of the world can be shared and contested, that participatory research becomes a political act.

Van de Ven (2007) notes how scientific knowledge and practical knowledge are often separated as distinct kinds of knowing. In drawing on a participatory inquiry paradigm in this study, the intent is to bring these together, to connect previously developed scientific knowledge with participants’ experience, and the dynamics of gender in the substance use field. Recognition is brought to how each form of knowledge is partial and dynamic, and to the benefits of a more pluralistic approach to knowledge production among scholars and practitioners.

3.2.2 Critical inquiry

The critical inquiry paradigm builds on the participatory one, to concentrate on specific local and global conditions within participatory inquiry, and to promote action on what is learned. Criticalists consider how “all thought is fundamentally mediated by power relations that are socially and historically constituted; facts can never be isolated from the domain of values or removed from some sort of ideological inscription . . .” (Kincheloe, McLaren & Steinberg 2011). The critical paradigm is also concerned with participatory action within and beyond the research process, with “fostering emancipation, democracy, and community empowerment and of redressing power imbalances . . .” (Lincoln, Lynham & Guba 2000, , p. 175).

Central to critical inquiry is empowerment of individuals through dialogue. Leading critical theorist and educator, Freire (1992, 2006) saw locally situated dialogue as important in order to facilitate transformation to critical consciousness (conscientization) and action based on this consciousness (praxis). He articulated the importance of: promoting the learner as subject of their learning, listening to generative themes of participants; and creating a structured dialogue within which everyone participates as a co-learner to jointly construct a shared social reality (Wallerstein & Duran 2003, p. 37). In the critical inquiry-based, popular education tradition,

individuals must not only be involved in dialogic efforts to identify their problems but also engaged in conscientization to analyse the societal context of these problems (Freire 2006). The goal of such dialogue and conscientization is praxis, defined by Freire as "reflection and action upon the world in order to transform it" (Freire 2006, p. 51).

A key aspect of the critical inquiry paradigm is the attention to the relationship between the researcher and researched, or facilitator and learners. Experts in knowledge translation have stressed how a more engaged relationship between the researcher and his/her audience is needed (See for example, Jacobson, Butterill & Goering 2003; McWilliam 2007; Van De Ven 2007). Freire saw the people he studied as partners in the research process. Feminists who have built upon Freire's work such as hooks (1994) continue to envision and enact less separation between the facilitator/researcher and the learners or research participants. Other contemporary advocates of critical feminist teaching and inquiry also see teaching and learning as a collective process of empowerment, where, in the process of engagement and critical reflection together, all have the potential to be transformed (See for example Daley 2010; de Saxe 2012; Merriam, Caffarella & Baumgartner 2006). The role of the teacher/researcher is discussed in a recent article by critical theorist Kinchoeloe and colleagues (2011). They describe how teachers in engaging in dialogue with students - a "dialogue that questions existing knowledge and problematizes existing power relations that have served to marginalize specific groups and individuals" (p. 166) - help students frame their problems in a larger context and consider how to solve them. In this process the teacher better understands generative themes, is able to tailor the co-learning process and to reflect on their own "subjective, intersubjective and normative reference claims" (p 167). Another theorist in the critical tradition, Giroux, also advocates for teachers to assume "their full potential as active, reflective scholars and practitioners" (Giroux 1988, p.124) that is, as "transformative intellectuals" who can "educate students to be active, critical citizens" and "speak out against economic, political, and social injustices both within and outside of schools" (p. 128). In this study the participants are considered co-researchers and co-learners interchangeably; and these roles and my role as researcher, knowledge translator, community facilitator and engaged scholar continuously interrogated. This stance clearly situates the study in the critical paradigm; directly challenges the view of researcher as knowledge translator as working from a

neutral (versus engaged), objective (versus intersubjective) and decontextualized (versus embedded in complex relations of power).

Another element of critical inquiry involves engagement with difference, hybridity, border crossing and resistance. Giroux focuses on how we learn of dominant ideologies and learn to question; how in learning there exists the possibility of resistance; and how "the mechanisms of reproduction are never complete and are always faced with partially realized elements of opposition" (Giroux 2006a, , p. 29). Giroux and feminist critical theorists such as Bickford (1996) and Young (2002) articulate the need for public spaces to support agency, participative debate, critical reflexivity, and a language of resistance that are essential to democracy. From the perspective of these thinkers it is important not only to map oppressive practices, but to engage in the ways in which knowledge can be "remapped, reterritoritalized and decentered in the wider interests of rewriting the borders and coordinates of an oppositional cultural politics" (Giroux 2006b, p. 51). Within such oppositional public spaces, there is recognition of the benefits of bringing together differently located perspectives, to create the potential for new hybrids of understanding and action.

A recent systematic review on the application of social constructivist learning theories in knowledge translation for health professionals (Thomas, A et al. 2014) distinguishes between social constructivist and critical paradigms, and situates current knowledge translation practice within the former. They illustrate how current revered knowledge translation models are based on a social constructivist paradigm, that is, one focussed on individual creation of knowledge in socially mediated contexts. This is a narrower frame than the critical paradigmic approach that also considers broader social, historical and cultural processes, including institutionalized practices, that affect knowing and underlie the needs for making gender, race and class visible and social action beyond individual meaning making and its application to clinical practice. This study, instead, privileges the critical paradigm and posits its usefulness in extending the limits of current gender-blind knowledge translation practice.

3.3.3 Feminist epistemology

The interest behind this study – to, as a researcher, understand how to promote engagement with, and potential action on, research on women's substance use on the part of practitioners, policy makers and other researchers – invites engagement with feminist epistemology and method. As Sprague has identified "reflecting on methodology . . . opens up possibilities and exposes choices. It allows us to ask such questions as: Is the way we gather and interpret data consistent with what we believe about how knowledge is and should be created?" (2005, p. 5).

Often in the health research world, researchers do not make epistemology an issue; they work from a positivist paradigm and take it as a given. In this context, feminist researchers are often seen as: not properly abstracting the object of inquiry from its context, as not "objective", as producing "opinion" not evidence. Yet increasingly in nursing, related health professional and feminist journals, women's health researchers are taking pains to identify and legitimize a constructivist epistemological stance, where knowledge is seen to be constructed in a specific matrix of geographical location, history, culture and interests (See for example Anderson, JM et al. 2010). This becomes the "requirements of responsibility and reproach that feminists have to negotiate" (Code 1995a, p. 32).

Feminist subjectivities matter within critical, participatory inquiry. Canadian feminist epistemologist, Lorraine Code states that "tacit assumptions about how knowledge can be acquired and validated have informed not only feminist research practices and activist conceptions of what issues are worth pursuing and why, but also feminist endeavours to understand that everyday manifestations of the gender-inflected power and privilege that permeate every society and social group" (Code 1995a, p. 19).

Code is concerned with the knower, known and the process of knowing, as a "social-communal affair". She speaks of it being imperative for feminists to *know* the situations of and circumstances of women's lives in order to explain the absence of women both as agents and subjects of inquiry throughout received public knowledge, and to develop valid workable analyses of oppressions and marginalizations from which emancipation must be achieved. We have to be able to articulate informed and

practicable strategies for transforming authoritarian knowledge and the social structures that it legitimates and informs. To develop such strategies feminists have to know these structures well enough to reveal their often invisible mechanisms for maintaining hierarchical social arrangements and uneven distributions of power that knowledge confers.

Tuana (2006) describes how the women's health movement in North America in the 1970s and 1980s aimed to:

> *reframe knowledge and experiences of our bodies in ways not configured by sexism and androcentrism. In this sense it was an epistemological resistance movement geared at undermining the production of ignorance about women's health and women's bodies in order to critique and extricate women from oppressive systems often based on this ignorance, as well as creating liberatory knowledges. (p. 3)*

Like Code she postulates that if we are to understand knowledge production we must also understand the practices that account for not knowing. In Tuana's view it was through consciousness raising and other dialogic and activist mechanisms, that ignorance of women's health was "sometimes disrupted" by the women's health movement of that era. As such, we must not only be concerned with how to generate knowledge but "understand how to identify, critique and transform ignorance" (p. 3).

The social, constructivist and communal nature of knowing has been further articulated by a feminist epistemologist, Grasswick, from the UK (Grasswick 2004, 2008; Grasswick & Webb 2002). She offers a conception of knowers as *individuals in communities* (p. 112) that serves as an epistemological foundation for the virtual community approach. As with other feminists interested in epistemology, she is concerned with knowers as individuals who are centrally understood as interactive rather than self sufficient, and situated rather than generic (p. 86). Grasswick accounts for our capacity for active reflective inquiry, how we are deeply interconnected in our knowing, and how agency or the existing social practices of knowing can be extended. In the *individuals in communities* view she sees that we develop within particular communities, and our capacity as active inquirers requires this history of social development within a communal context. Our histories of having lived within specific communities and having learned a wide range of epistemic skills within those communities contributes to the particularization of individual knowers. One's capacity

for active reflective inquiry emerges from the experience of reciprocal relationships of knowers recognizing each other as knowers and inquirers. The partial nature of our epistemic locations underpins the epistemic benefit to be reaped by considering the perspectives, claims and epistemic tools of others and that social connections must be forged (p 108). We cannot assume that a given epistemic practice will serve all equally well, instead through membership in various communities people have the opportunity to learn and evaluate various knowledge seeking practices. Learning communities such as that created in this study are relevant as the quality of social relations between knowers has a bearing on their capacities to critically engage with each other epistemically. Trust is required along with the recognition of the variation in interests (epistemic and otherwise) of the different parties involved.

Participatory inquiry, critical inquiry and feminist epistemology and inquiry are fluid, overlapping and mutually reinforcing paradigms, which are brought here to the practice and study of virtual communities. One Swedish educator has actually entitled an article “Critical action research and third wave feminism: A meeting of paradigms” (Weiner 2004). These paradigms and the forms of inquiry arising from them challenge pretensions to certainty, precision and neutrality in positivist approaches to scientific method, and embrace inclusive, collaborative and activist approaches.

3.3 Theoretical framework

> *Feminist practice as I understand it operates at a number of levels: at the level of daily life through the everyday acts that constitute our identities and relational communities; at the level of collective action in groups, networks, and movements constituted around feminist visions of transformation; and at the levels of theory, pedagogy, and textual creativity in the scholarly and writing practices of feminists engaged in the production of knowledge. (Mohanty 2003, p. 5)*

The theoretical framework for this study is a feminist one. Feminist theory aims to understand gender inequality and promote gender equity. Naples (2003) notes that feminist theoretical perspectives were developed in the context of diverse struggles for social justice inside and outside the academy. One location of feminist theory building was consciousness raising (CR) groups, in North America in the 1970’s. In CR groups women shared experiences from their own lives, “finding similarities and patterns

which they interpreted not as evidence of individual women's inability to cope, but rather evidence they were trapped in unjust systems of social arrangements" (Jaggar 2007a, p. 192). Such sharing and collective analysis made visible and possible the theorization of gender inequities such as violence against women. In so doing, Jaggar speaks of how early second wave feminism invented the use of gender as a category for analyzing social life, a methodological tool which has been further developed and applied over the past two decades.

Building from such early multi-located theorizing, knowledge building from a constructivist feminist framework becomes a relational process rather than an objective product, a process involving critical self reflection, dialogue and interaction (Collins 2000). In such knowledge building processes, feminist researchers often privilege lived experience as a source of evidence, and at the same time acknowledge that experience and all knowledge claims must be interrogated and "decentred" (Narayan & Harding 2000). Considerable healthy debate has taken place within and between feminist streams of thought, as to how in social criticism and theorizing, we avoid grand metanarratives that essentialize women as a category, attend to differences and to cultural and historical specificity, and at the same time are able to identify and address causes and constitutive features of sexism (Fraser & Nicholson 2008). Feminists continue to attend to how knowledge is situated, and seek new ways to approach knowledge building. Third world women's writings on feminism have consistently focused on the idea of simultaneity and interlocking nature of oppressions as fundamental to the experience of social and political marginality (Hill Collins 2008, p.310; Mohanty 2003, p. 52). As feminists attend to experiences of diverse women, through listening to the criticisms of poor and working class women, women of colour, and lesbians, the need to challenge sexism, racism, colonialism, class and other inequalities is forefronted in feminist theories. Miles (1996, 2013) describes how it possible to affirm women's equality and specificity, and to see them as dynamic contradictions to be lived and transformed in practice. In this way, feminists worldwide are not assuming "a global homogenous feminism" (Olesen 2011).

As such feminist theory is the important theoretical foundation to this study as it:

- is concerned with how gender shapes the construction of identities and social relations and how gender becomes institutionalized (Johnson, J, Greaves & Repta 2007);
- names and validates the concerns of women who are marginalized in capitalistic, patriarchal society, countering prevailing ideologies and power relations that are deeply gendered (Kim, HS 2007); thereby linking multiple forms of structural inequality, such as race, ethnicity, class and sexuality with gender.
- attends to the epistemic reliability of knowledge claims by taking into account the circumstances in which these claims were produced.
- has an action-oriented, social change and social justice agenda. "Feminists' political commitments have enabled them to recognize evidence that others have thought unimportant, to discern patterns that that others have ignored, to question assumptions that have gone unnoticed and unchallenged, and sometimes to reframe the research agendas of their disciplines in light of different questions." (Jaggar 2007a, p. 307)

3.4 The research question

The research question - how can short-term, multisectoral, virtual communities foster the application of co-constructed knowledge on marginalized women's health, and contribute to the understanding of both knowledge translation and contemporary feminist action research – has clear foundations in these participatory and critical paradigms and in feminist theory and practice.

Models for engagement and collective learning which are based in feminist consciousness raising, popular education and communities of practice are drawn upon in the design employed to answer this research question. Overall, this study is concerned with knowledge translation (research to praxis) on marginalized women's health issues, as potentially facilitated through virtual communities of inquiry. Of specific interest are: what brings people to voluntary online research, learning and potentially activism; who comes to virtual learning communities, and what forms of diversity do they bring; how/do participants see the virtual nature of the community contributing to interaction, framing and reframing of issues; how is evidence shared and

weighed; are multiple perspectives heard; are different perspectives tried on; what insights arise; do assumptions change; how is the context of the issues understood; how do participants see relations of power operating to affect discourse and action on the issues, and how/does this contextual understanding become integrated in the participants' ideas for action; what post community action do participants see as important/relevant, both individually and collectively, and how/has the community process affected participants' approach to their work/activism?

3.5 Research design

> *Participatory research taught me the necessity of being explicit about personal choices and values in the research process. Feminism taught me to recognize that the personal is political. Patricia Maguire (as cited in Kirby, SL, Greaves & Reid 2006, p. 33)*

In this study, a virtual community is designed to support gender-based analysis of girls' and women's substance use and addiction. The virtual space is used for examining the gendered experience of substance use and gender inequality, to make possible wider involvement in analysis and action for participants. This research attends to how researchers, practitioners, activists and policy analysts can be involved in making women's experiences visible and respected as a legitimate endeavour. It recognizes that the various forms of evidence and experience (research, lived experience, clinical and policy wisdom) need careful interpretation, especially to reveal both how women's experiences are embedded in larger social patterns, and at the same time are mediated by circumstances of biographical and social cultural location. In this case, the research is using the individual experience and agency of participants to examine the larger patterns of restriction in our understanding of women's experience of substance use; and is opening up the opportunity for gender-based analysis and responses.

The study is concerned with analysing virtual mechanisms for their potential to foster reflection and action on women's health. Within the virtual community created, power relations and structural barriers to change are examined, with a view to understanding if, where and how change at these levels may reduce the marginalization and discrimination directed to women who use substances. The research applies a

critical feminist lens to the community and post community outcomes to understand how/if consciousness raising takes place, and how/if collective participation in knowledge sharing and analysis catalyses participant action.

The research methods flow from the choice of paradigm and theoretical framework, and are, the same time, the object of the study. That is, a virtual community (drawing from community of practice and community of inquiry approaches) is created as a method, based on participatory, critical and social learning paradigms and feminist theory, and these paradigms are applied as analytic lens to provide the basis of statements of the role of such communities to achieve knowledge translational goals in the health field.

This research is an examination of a virtual community, that is, a case study. In Stake's (2000, p. 437) classification, it is an instrumental case study, as a virtual community is examined to provide insight into virtual communities with comparable goals of: multisectoral participation, collaborative knowledge construction and synthesis, and contextual and structural analysis; and fostering the application of this collectively synthesized knowledge in multiple domains.

The case is analysed in the light of:

- how the components of feminist action research – such as inclusion, participation, individual and collective action/efficacy, social change, empowerment – are, or are not realised.
- how current approaches to social learning such as communities of practice, specifically those with foundations in dialogic processes, conscientization and transformative learning can support knowledge translation goals on complex health issues
- how virtual locations can facilitate the process of sharing knowledge across boundaries (geographic, sectoral, cultural), and the potential for scholars to act as brokers, facilitators and boundary spanners in such processes.

Cancain argues that feminists use distinctive methodologies that fit the feminist goals of challenging inequality and empowering women and marginalized groups. Drawing from the work of Fonow and Cook (1991) she discusses how feminist methodology: focuses on gender inequality; includes the everyday experiences of

women (and men) especially women on the margin; includes an action or policy component aimed at social transformation or improving the conditions of particular women; analyzes how the research process is shaped by the gender, race, class, and sexual orientation of the researcher, and by the broader social and cultural context; and favours methods that give research subjects more power.

Another key aspect of feminist methodology is the commitment to reflexivity as a source of insight. Fonow and Cook define reflexivity as "the tendency of feminists to reflect upon, examine critically and explore analytically the nature of the research process" (1991, p. 2). Reflexivity requires the researchers to address power imbalances along the entire research process, engaging participants in the telling and interpreting of their own lives and experiences.

This study is an example of feminist action research, and the elements of feminist action research are used as an analytic tool to elucidate effective knowledge translation processes. Feminist action research (FAR) is a conceptual and methodological research framework that is fundamentally about exploring and pursuing opportunities for social justice. As Reid and Frisby (2008) have argued, it brings synergy to the strengths of feminist research and action research traditions, addressing the joint criticisms of action research for its lack of attention to gender relations; and of feminist research for its lack of a articulated framework for translating feminist insights into concrete actions aimed at achieving social change. This current study has the goal of both using feminist participatory action research as a method, and to extend understanding of its workings in the virtual context.

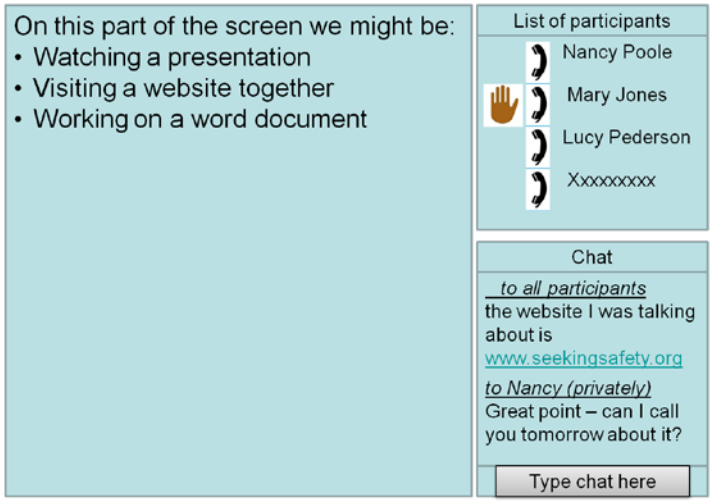
3.5.1 The virtual infrastructure

A tailored virtual setting was designed for the virtual community of practice (vCoP). The setting took into consideration principles from participatory action research, adult learning, and online learning practices.

The online environment chosen had the two central components of webmeeting and web workspace functions. The vCoP was centred around the (synchronous) webmeeting function, where participants were invited to join a series of webmeetings, a

format that allows participants to easily see and hear presentations, participate in discussions and send messages to the group or to individual members (see Figure 1). To attend, participants clicked on a weblink to join the meeting (videoconferencing) and called into a toll free number (audio conferencing).

Figure 3.1. The 3 part screen participants see during a webmeeting: 1. the main presentation section, 2. the list of participants (with one person indicating they wish to speak), and 3. the chat function (showing a chat message to all, and to one member only)



These meetings were scheduled once a month over a six month period. The meetings were one hour and a quarter hours in length (75 minutes). The length of the meeting allowed for introductions (15 minutes) a short presentation (15 minutes), discussion (40 minutes) and a wrap up (5 minutes).

In addition, a tailored, password-protected virtual workspace was designed. This virtual workspace featured: a landing page where announcements, meeting times, weblinks and tasks were posted for quick reference (See Figure 2); an email function where members could send emails to the whole group, subgroups or individual members; a document repository where documents were organized in folders by topic, and a discussion board where participants could carry on asynchronous conversations in organized threads. By signing into this virtual workspace, participants could access materials and links, and communicate between webmeetings from any computer at home or work.



Figure 3.2 – A screen shot of the landing page showing key functions such as announcements and calendar, as well as a drop down list of other screens (left hand side)

A related virtual function, a website (www.coalescing-vc.org) held some key documents on the topics discussed by the vCoP and served as a public interface which participants could share with colleagues. See Figure 3.3

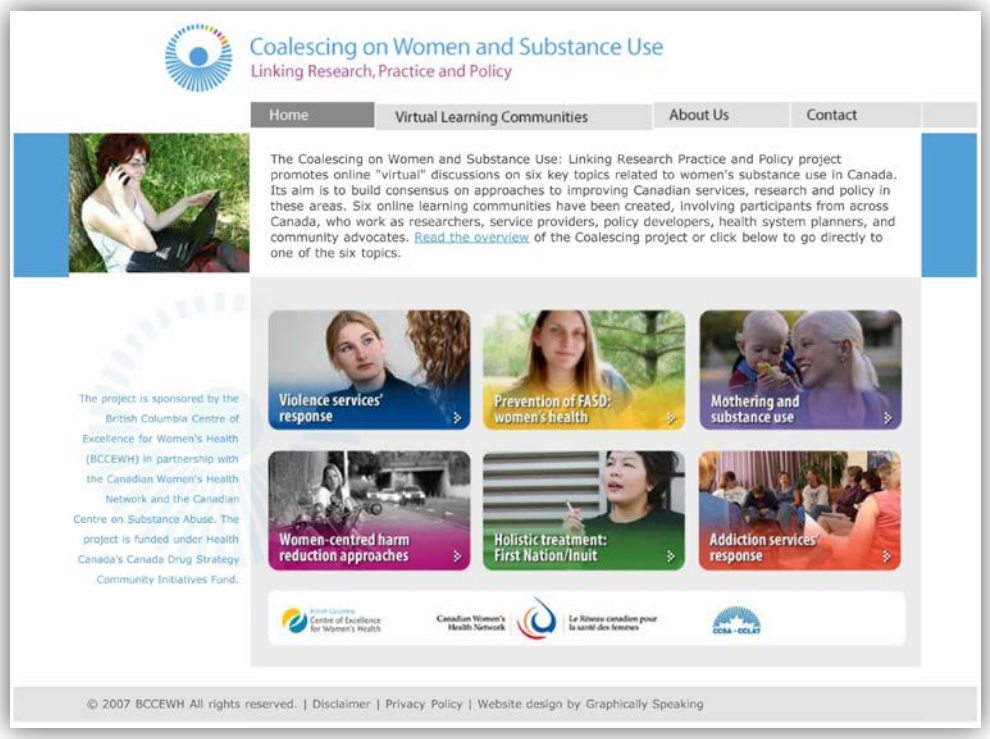


Figure 3.3 – A screen shot of the associated website (www.coalescing-vc.org), a public interface on the topics discussed by the community.

The webmeeting and web workspace functions were chosen to support participants to identify, access, and examine current knowledge (research-based evidence, practice-based evidence and personal experience) on topics related to improving treatment and support for with women substance use problems; and to collectively discuss and synthesize this knowledge, consider practices of power that create barriers and opportunities to progressive change, and avenues for applying the co-constructed knowledge in the context in which they work. The webmeeting and web workspace functions were chosen to support the three forms of online presence identified by Garrison and Anderson (2003): cognitive, social and teaching presence. Together these three presences support an educational experience characterized by: ability to collectively construct meaning, be known as individuals and have effective facilitation of learning.

3.5.2 The design of the virtual community sessions

To begin, brief orientation sessions were offered, to allow participants to practice connecting to a webmeeting and to introduce participants to the features of the webmeeting and web workspace infrastructures. In this and in all subsequent meetings, participants were encouraged to ask for help with technological issues, to consider this community as safe place to "learn the ropes" of connecting/working virtually.

From the orientation on, in each session, a tone of learning together in a positive and appreciative way (Reed 2007) was introduced. For example, the positive tone was set through encouragement to ask each other for clarification of ideas, and to share perspectives on what is working as well as what is lacking.

Each session's agenda had three core components: the opportunity to introduce oneself and update each other on developments in one's workplace since the previous session; an instructional component, and a dialogic component. A range of approaches to the instructional component were used to promote engagement, as will be seen in the following detailed description of the content of the sessions.

The first formal session was structured to allow participants to: introduce themselves (in a lengthier way than in following sessions); be introduced to evidence on key sex and gender differences in substance use; to have the opportunity to reflect on the implications of these differences; and to discuss the content of the following session(s).

The agenda for the first session, February 23, 2009 was:

1. Introduction to the community purpose, and structure – 5 min
2. Participant introductions - 20 min
3. A 10 question quiz to illustrate sex and gender differences - 10 min
4. Presentation on sex gender and diversity based analysis, applied to substance use/addiction - 10 min
5. Open ended discussion - 20 min
6. Next steps – 10 min

Before each of the following sessions, participants were alerted to the availability of documents and links posted on the web workspace, if they wished to explore them prior to the session. In each case, the documents included a sampling of what is in the recent literature on the topic, a short backgrounder which summarized the current literature and current treatment approaches being implemented, and a list of internet links to reports and programming. The internet links could also be accessed directly from the landing page of the workspace.

The agenda for the second session, March 27, 2009 reflected the participants' strong interest in discussing trauma-informed practice and included:

1. Introductions – 15 minutes
2. Presentation on the rationale for the substance use field to base practice in an understanding of the interconnection of experiences of trauma and violence with substance use problems in women – 5 - 10 minutes
3. Description of the process of taking a trauma-informed approach to treatment by a women's treatment centre in Toronto - 15 minutes
4. Discussion using the following two questions as prompts: 30 min

- Why do you think we have not attended to this important intersection with substance use to date?
- What opportunities are there for building awareness/taking action on these intersections to improve the response for girls and women with substance use problems and related trauma and mental health concerns?

5. Wrap up and discussion of content of the next meeting - 5 – 10 minutes

After the 2nd meeting an e-survey was conducted to capture participants' views of the community to date and ideas for topics for further meetings.

The agenda for the third session, April 22, 2009 was focussed on treatment, prevention and harm reduction interventions for girls. It included a presentation by one of the community members on her work with Aboriginal girls and involved:

1. Introductions

2. Brief overview of the literature about gender and treatment/prevention and harm reduction with young people
3. Presentation of the gender-specific Aboriginal Youth Solvent Addiction (YSAC) approach in place in treatment centres for Aboriginal girls/young women and boys/young men, by a community member
4. Discussion of the YSAC approach, and other programs/ initiatives/ research involving young people, and discussion of implications for our work, and for the implementation of the National Framework
5. A brief look at the results from the e-survey on views of the community to date, and ideas for topics for the next meeting(s)

The agenda for the fourth session, May 29th, 2009 took up the topic of addressing the needs of pregnant women and mothers in the context of work on substance use prevention, harm reduction, treatment and policy making and included a guest speaker from an innovative program in Toronto. It included:

1. Introductions
2. Presentation of the work of a women's treatment centre in Toronto on programming for women with substance use problems and their children
3. Presentation on the construction of risk related to drinking in pregnancy, as well as Canadian prevention, treatment and harm reduction programming that is designed to help women prevent FASD
4. Discussion of implications for our work on alcohol policy, and on intervention and support with women who are mothers and children
5. Wrap up and discussion of topic for next meeting

The agenda for the fifth session, June 26th, 2009 was focussed on gendered harm reduction principles, practice and policy, and how these principles, practices and policies are, or are not, addressing the realities for girls

and women using licit and illicit drugs and facing many other interconnected risks. Participants were encouraged to invite additional people who might contribute to, or benefit from, the discussion since harm reduction practice is less well established, than treatment or prevention programming in Canada. The agenda for the final session included:

1. Introductions
2. Presentation of the backgrounder on the rationale for, and scope of, harm reduction programming for girls and women
3. Discussion of how harm reduction goals are being realised in practice and policy affecting girls and women across Canada
4. Wrap up

3.5.3 Identifying vCoP participants

The aim of this project was to create the opportunity for people in a position to influence substance use policy and practice in Canada, to choose to learn more about gender, women and substance use, and to consider their role in improving the system of care based on that learning. An excellent opportunity existed for identifying potential participants through partnering with the Canadian Centre on Substance Use (CCSA) to involve people working on the *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada*.

Between 2004 and 2009, CCSA with Health Canada had held Canada-wide consultations to develop the *Framework*, setting out thirteen (13) priorities for action, and pulling in endorsement by over forty partner organizations. I and other feminists had advocated for work on girls' and women's substance use to be made a priority, but this did not materialize. However in May 2008 at a national meeting on progress on the early implementation of the *Framework*, strong support for applying a gender lens across the priorities was identified:

> *Further, participants stressed the need to apply the National Framework principle of "those most affected are meaningfully involved", as well as a gender lens and a First Nations, Inuit and Métis lens to all recommendations and strategies. The following populations should be considered in all priorities:*

women, seniors, children of prisoners, immigrants and the homeless. (Canadian Centre on Substance Abuse July 2008, p.7)

Accordingly the people working on the *Framework*'s thirteen priorities seemed a fitting group to invite to participate in the virtual community. They were researchers, practitioners, and health system planners working in many locations across Canada – all in a position to lead and participate in change, to improve the response to women with substance use problems in Canada. The leaders of the national strategy within CCSA were approached and they agreed to promote awareness of the research to the *Framework* participants and support the involvement of their Senior Research Associate in co-facilitating the community. Accordingly CCSA's Senior Research Associate and Director of Knowledge Exchange co-signed the invitational email sent to those involved in action on the *Framework*. This list proved to include over 300 individuals.

One other group seemed important to include - advocates currently working on prevention and treatment with girls and women. There was no national list to identify this group, however a provincial conference on women's treatment, entitled *Gender Matters* was being sponsored by Canada's best known women's treatment program, the Jean Tweed Centre in Ontario (Canada's most populous province) at an opportune time for promoting interest on the part of this sector. A postcard was distributed at that conference in May 2008, inviting people to indicate interest. See Appendix 1. However as it turned out no participants in the vCoP indicated their involvement was linked to this recruitment mechanism.

3.5.4 Recruiting vCoP participants

The participants were recruited by email using the Canadian Centre on Substance Abuse's email list of people working on the *National Framework*. See Appendix 1 for the content of the invitational email.

The participants were invited to explore women's substance use, gender-based analysis and practice approaches. While feminist practice was utilized in its design, and a feminist analytical lens was applied to the outcome, I did not use the term 'feminist' to apply to community in the recruitment. This stance allowed participants to directly

experience a critical feminist process, and then to take stock “of its authentic value and of its restricting bias” (Heron & Reason 1997, p. 282) without being forced to identify with feminism.

3.5.5 Data collection

The focus of this research is on the action taken by vCoP participants post community, which can be attributed to participation in the community of practice/inquiry. To capture the impact of the community, an extended focus group method (Sussman in Berg 2004, p. 137) was utilized. The extended focus group method included an online survey followed by an online focus group designed to capture participant reflections on how/if their practice had changed following participation in the virtual community. The webmeeting format - with which the participants were familiar from their community participation - was used as the platform for the online focus group. The focus group was recorded and transcribed for analysis. The five core questions (and probes) used in the focus group are included in Appendix 2.

The focus group method is congruent with feminist research principles, particularly in this case, as they can serve as a form of consciousness raising in themselves (Kamberelis & Dimitriadis 2011; Wilkinson 1999). They have an emancipatory potential in that they give can voice to women’s experience, validation of that voice, have synergistic potential, and provide space for collective testimonies and group resistive narratives (Madriz 2000). As such building on group dynamics they can provide data not produced through individual interviewing, spark insights not generated by individual reflection. “Focus groups surface the dialogic possibilities inherent in but often thwarted in both in everyday social life and in research practice” (Kamberelis & Dimitriadis 2011, p.556).

Over the duration of the community, the monthly webmeetings were also recorded and the dialogic portion of each meeting transcribed. The transcripts of these portions of the meetings allow for description and analysis of collective knowledge generation and exchange, and the quality and extent of reflective processes achieved within the communities.

Finally, the four documents produced post community, which were based on the community discussions, serve as another source of data on the outcome of the virtual community process. These four documents (Poole & Urquhart 2009, 2010; Poole, Urquhart & Gonneau 2010; Poole, Urquhart & Talbot 2010) are available on the public website created in the course of the project (www.coalescing-vc.org) and appended as Appendix 3.

3.5.6 Analysis

Qualitative analytical methods are utilized to analyse the discussions from the community topical sessions, and post community focus group discussion of participants' application to practice and policy. This data was analysed in the light of feminist research/pedagogical practices, collective learning/inquiry processes, and critical, virtual pedagogy. The implications of these analyses are then considered for their implications for knowledge translation theory and practices.

Data analysis is conducted using qualitative data analysis software, NVivo 8. Initially the material from the transcripts of the post community focus group and the dialogic portions of the five community sessions were coded using priori codes based on key concepts from participatory feminist action research, social and transformative learning, and virtual learning. See initial coding frame in Table 3.1.

Table 3.1 - Initial Coding frame

Feminist action research	Social and transformative learning	Virtual learning in community
• Gender - consciousness of gender inequality, gender oppression, invisibility of women's needs. (Operation of power is relevant here, and as a cross cutting theme.)	• promoting awareness of context, critical reflection of context, questioning of assumptions, premise reflection	• access and ease of use of technology (web meeting and web workspace)
• Participation, give voice to participants' experience, linking up experience, reflexivity	• dialogue, bringing experience in, bringing critical reflection into action, consensual validation	• virtual support for community building, collaboration, connection, "social presence" (being able to project oneself socially and emotionally)
• Inclusion/diversity - opportunity to collectively consider difference, multiple perspectives	• relational teaching, establishing meaningful relationships	• virtual support for inquiry, knowledge building, critical engagement, "cognitive presence" (ability to construct and confirm meaning)
• Action discussion of action, individual and collective, social change agenda, social justice	• Collective meaning making , action on learning	• virtual "teaching presence" (facilitation and direction of cognitive and social processes)
(Lykes, M. Brinton & Coquillon 2007; Maguire 2008; Reid 2004)	(Baumgartner 2001; Mezirow & Associates 2000; Taylor 2009)	(Garrison & Anderson 2003; Swan & Shea 2005)

Themes consistent with key concepts arising from participatory feminist action research and social/and transformative learning in communities of practice (CoPs) and inquiry (CoIs), as well as emergent themes are identified and discussed, for their contribution to the understanding of the application of such theory and practice in the virtual context, and as well as implications for subsequent virtual and non-virtual agency. The meanings and interpretations that participants brought to the topics discussed, how they construed developments in the field and what guided their actions were key phenomena coded.

This approach to analysis, using a coding frame that draws upon components of feminist action research, aspects of learning in community and learning in virtual

contexts is consistent with the research interest in how virtual learning communities can contribute to the understanding of knowledge translation and contemporary feminist action research. It incorporates bricolage (Kincheloe, McLaren & Steinberg 2011) advocated by critical researcher doing multidisciplinary work who are "pushing to a new conceptual terrain" (p. 168). Critical bricolage involves the process of employing multidisciplinary research knowledges and methods to reflexively understand and expand one's conceptual understanding of complex contexts. It involves viewing "research methods actively, rather than passively, meaning that we actively construct our research methods from the tools at hand rather than passively receiving the "correct" universally applicable methodologies." (Kincheloe et al. 2011, p. 168).

The community-based approach to the inquiry and linking of feminist, learning and virtual pedagogies in the analysis demonstrate the integration of what Bradbury and Reason call three key manifestations of work in action research (2003, p. 235): work for oneself (first person research practice where I explore my role as community organizer, facilitator, boundary spanner, and engaged scholar); work for partners (as second person research practice, learning together in community in a way that is generative of new knowledge, new paradigms for understanding praxis, and principles for action); and work for people within the wider context (third person research practice through use of discussion guides, websites and the model of the community itself to prompt new understanding of knowledge translation and gender-specific practice and policy in substance use field). In addition Bradbury and Reason's key "choice points" (2003, p. 239) as to quality and validity in action research (listed in italics below) have been taken into consideration:

- *The research is explicit in developing a praxis of relational participatio*n - In this community of inquiry participants experience relational participation and are helped to see this an important aspect of learning, knowledge generation, and translation to practice and policy.
- *It is guided by a reflexive concern for pragmatic outcomes* - In this case this is achieved both by discussing praxis throughout the research, and by asking participants eight months post community to reflect on the action they have taken toward bringing the learnings from the community into their day to day practice. Another way of describing the importance of this follow-up, is that it provides "catalytic authenticity" (Mertens 1998, p. 185)

- *It has conceptual and theoretical integrity* - This research is grounded in feminist theory and participatory, critical and feminist epistemological paradigms. These foundations embrace complexity, recognize agency of participants and acknowledge the complications of power.
- *It includes extended ways of knowing* – This inquiry examines knowledge building as a relational process as in the early CR groups, where silenced discourse in uncovered, and situated, and iterative ways of knowledge building are valued (Hesse-Biber & Piatelli 2007). It promotes consideration of extended ways of knowing as foundational to the current practice of knowledge translation in health, that takes gender into account.
- *It can be considered significant*. The inquiry comes out of a concern for evidence-informed and equitable health care practice, with the potential to improve the lives of women marginalized by their substance use, experience of violence, poverty and related determinants of health. It is significant in its model for engagement in knowledge translation through virtual communities of inquiry that have the potential to generate action in health practice and policy that is not only instrumental but affects multiple determinants of health and is gender transformative.
- *It leads toward a new and enduring infrastructure.* This research invites re-examination of CR methods and their use in modern virtual community infrastructure.

3.5.7 Limitations and ethical issues:

The key limitation of the research is inherent in a case study approach. This is but one case of a virtual community undertaking cooperative inquiry, and as such the transferability can be seen to be limited. This study is designed to show the potential of communities, when using similar methods, to invite learning and promote action on marginalized women's health concerns; and to invite consideration of virtual communities as knowledge translation mechanisms overall. In qualitative research such as this, the issue of generalizability of transferability is determined by the reader, based on the provision of sufficient detail or "thick description" of the "time, place, context and culture" (Mertens 1998, p. 183).

Understanding one's location as researcher is vitally important in collaborative research involving diverse participants. It involves considerable reflexivity and openness about the choices made throughout, and understanding the fluid nature of one's role, continuously negotiating the positions of outsider and insider. Reflexivity involves recognizing one's location and experiences and deeply considering the implications of one's power (Kirby, Greaves & Reid 2006, p. 39). There are many points when I may not have been sufficiently aware of power differentials related to my role in catalysing the community, as well as to class and race and other inequities. It is also possible that in the negotiation of participant-researcher collaboration and in the analysis I may have privileged my voice over the participants' voices (Berryman, SooHoo & Nevin 2013). The unlearning and the humility required in building collaborative research relationships is considerable (Valenzuela 2013). Of particular importance is the extent to which a researcher can be open to findings, even when they violate one's expectations and/or threaten one's interests (Kirby, Greaves & Reid 2006, p. 40). As such the extensive quoting of participants herein is designed to allow the reader the opportunity to 'hear' the findings directly, and thereby validate the conclusions drawn.

As noted by Lather in 1986, as a praxis-oriented researcher I was interested in "obtaining and defining trustworthy data which avoided the pitfalls of orthodox notions of validity" (Lather 1986, p. 270). She raised important standards and practices for validity appropriate for research "that is openly committed to a more just social order" (ibid.). At the initiation of this study I carefully considered how to engage systematically with all the aspects of validity she identified: triangulation, reflexivity, face validity and catalytic validity. In so doing, I considered ways in which I might: avoid imposing theory on the experiences of participants in unwarranted ways; notice how participants may be offering perceptions that do not serve their best interests (false consciousness); and foster participants' involvement in "knowing reality in order to transform it" (achieving conscientization) (Lather 1986, p. 272). These challenges while approximated, are unlikely to be fully achieved in this study method and documentation. Then, over the course of this study, Lather proposed (and at the same time challenged) further standards of what she termed "transgressive validity" (Lather 2007, pp. 128-129). Transgressive validity encompasses notions of validity that bridge

critical feminist and poststructural research methodologies. Transgressive validity includes (but is not limited to, or a recipe for being):

- "anticipatory of politics that desires both justice and the unknown, but refuses any grand transformation . . .
- concerned with . . . . complexities. . .
- searches for the oppositional in our daily practices . . .
- brings ethics and epistemology together" (ibid.)

These concerns underline the challenges and limitations of undertaking research situated in times of enduring positivism, advances in decolonizing and transnational feminist activism and developments in poststructural thought. A reality and limitation of this study is that the conclusions are necessarily uneasy, partial and positioned.

The next chapter will introduce the findings arising from the use of these methods. It will describe the participants who came to the virtual community, identify the emergent discussion topics, provide an overview of how the discussions unfolded, and offer participants' reflections on the impact of their participation eight months following the implementation of the community. Then the following three chapters will use the lens described here in the initial coding frame - feminist action research, social and transformative learning, and community-based virtual learning - to weigh the virtual community of inquiry model for its potential to enhance knowledge translation on complex women's health issues.

Chapter 4 – The virtual learning community enacted

This chapter describes the virtual community: the participants it attracted; the topics discussed; and how the collective learning processes unfolded. The chapter provides a view of this exemplar of a virtual community built to achieve goals foundational to knowledge translation, feminist participatory action research, transformative learning and distributed (virtual) involvement. All of the findings provided in this chapter about: whom the community attracted, motivations for participating, topics identified by participants as important, the virtual infrastructure employed, and follow-up actions attributable to participation will then be considered in subsequent chapters in the light of these key lenses of feminist participatory action research and consciousness raising, enactment of communities of practice or inquiry, transformative learning and online learning.

4.1 The participants

4.1.1 Who came?

The community was remarkably successful in attracting participants, who were diverse in geographic location, workplace sector, and knowledge of gender issues.

The goal was to involve participants who were researchers, practitioners, health system planners, and/or women's health advocates working on prevention, harm reduction and/or treatment on substance use issues from across Canada. Consistent with the aims of feminist participatory inquiry research, the intent was to be inclusive of participants working in a range of sectors (practitioners working for government and non-government organizations, system planners, researchers, and community advocates), from a range of locations, and diverse in age, race, gender and other demographic attributes.

The invitational email went out to a list of over 300 people who had participated in consultations related to the National Framework or in more active involvement in its development. Thirty eight (38) people indicated interest based on this invitational email.

- People from 9 of 13 provinces and territories expressed interest.

- 18% were from the north of Canada (living at or above 53 degrees latitude, excluding Edmonton)
- 16% were from rural locations (living in communities with a population under 8,000 people)
- 8% were men
- By role they were (where participant some had more than one role, a lead one was assigned)
    - System planners or decision makers (in health, social services or corrections systems) 13 (34%)
    - Service providers, practitioners, service managers (in treatment, corrections, prevention services) 12 (32%)
    - Educators/ knowledge translation or communications expertise 4 (11%)
    - Non-government organisational leaders 3 (8%)
    - Researchers 3 (8%)
    - Policy advisors (in government advising decision makers) 2 5%
    - Women's advocates 1 (3%)

As such, the goal of attracting people from multiple sectors and locations was achieved at this first level of engagement.

It had been planned to ask for consent only for participation in the focus group at the end of the community, however the UniSA ethics research board required two stages of consent; that is, consent for participation in the virtual community meetings themselves, as well as for the post community focus group. This requirement appears to have created a barrier to engagement. For when the 38 interested participants were asked to fill out a consent form related to basic participation in the community, approximately half did not follow up. The reason for not taking the step to complete the consent form is unknown, but it is likely that asking for formal consent at that point was inconsistent with the informal, voluntary, co-learning approach to which the community of practice was purporting to adhere. Thus the community included twenty participants plus speakers invited to some sessions. The representation of the final group did not change from those who indicated interest in terms of the mix of roles or geographic representation but the final group did not have any male participants. However one of

the male participants asked to be kept informed of the group process through the discussion guides, and post community assumed an advocacy role on women's substance use issues.

The multiple sectors represented by those who did participate in the community were significant for the collective learning process. This diversity served to move the community beyond any dichotomous positioning, for example beyond an academic-practitioner exchange, Instead, as will be seen in the quotes provided throughout this thesis, the diversity prompted reflexivity about their own and others' varied social positions in relation to the substance use field, In addition the multisectoral as well as the time limited nature of the community appeared to prompt a "swift" versus a gradual and deep trust between members (Levin & Cross 2004); and affords a view of what can be achieved through weak ties in such contexts. As will be discussed further in Chapter 6 this diverse, experienced, and geographically-distributed participation underpinned a different form of learning community than a typical community of practice, which is normally characterised by trajectories from apprenticeship or neophyte learners to expert.

The participants all had considerable expertise in the substance use field, yet varying levels of knowledge of sex- and gender-based analysis (SGBA) and its application to practice and policy. The engagement from multiple sectors and with varying expertise on gender-based analysis also allowed, as will be discussed, for participants to see how each location (practice, policy, research, experiential women) faces comparable systemic level constraints and marginality when working on gender issues in the substance use field. It further prompted awareness of each sector's responsibility to act to improve the lives of women with substance use concerns, to not leave the burden of raising awareness and promoting action on the shoulders of women with substance use problems only, as has often been the case (Greaves & Poole 2005).

4.1.2 What was the draw to participate in knowledge exchange about gender?

Participants expressed both interest in improving their practice related to women and substance use, and curiousity about learning in a virtual community context.

In the introductions at the first meeting participants indicated they were motivated to learn about gendered topics which are determinants of women's health and substance use, and to consider the application to practice in their specific context:

> *And I'm really excited to be a part of this community and I think, in particular, because I've been working in the North for -- for a few years, just really been amazed, you know, to see the strong link between trauma and addictions and violence and mental health, so I'm interested in knowing more and to be able to share that with other people who may be -- are unaware of those -- of those linkages.*
>
> Addiction service provider with a First Nation in a northern territory

> *We're really interested in this forum because we're the only female institution in the province. We have a very large number of Aboriginals in the institution and there's a lot of trauma and there's a lot of substance use. So anything we can learn from anybody would be really, really helpful.*
>
> Coordinator in a women's correctional service

Participants also mentioned their interest in learning for the purpose of sharing with others in their workplace, system of care or province:

> *So I'm just really excited to be part of this learning process and I will be able to share this information with my co-workers. So I'm really looking forward to expanding our knowledge here at the Centre*
>
> Violence prevention worker with a women's centre working in school setting

Some explicitly saw the learning context – the virtual community location – as their motivation for involvement:

> *So am pretty excited to be involved in this virtual community of practice, very interested in online learning and e-learning and that kind of thing, so this is multi-level learning for me. I also have just written a course on gender-informed practice in addiction treatment and so I hope I have something to add and I know I'll have lots to learn, so thanks for the invite.*
>
> Educator for a provincial addictions agency

> *So I come with sort of two hats as far as prevention and clinical piece. But also just wanting to explore this type of community of practice. We do a lot of community practice work . . . but in a much different sort of setting, probably less formal and certainly using, you know, teleconference and those kinds of things, and video conference. So I'm quite excited to see how this all emerges.*
>
> Government policy and program developer working at the provincial level

The responses offered by the participants in the focus group held eight months post community, as to what brought them to participate in the virtual community

confirmed these interests in learning and sharing, and stressed to an even greater extent, how important and successful the virtual context was for them.

> *For me, aside from having an opportunity to learn and understand more about an area that I'm just interested in as a practitioner in the field, it also is some new, it's a new avenue for learning; the web-based sort of work . . .*
>
> *So you know, how I came into this initially was just mostly from my job at the time, which was about, you know, writing, developing learning content for addiction staff, and specifically focused on prevention curriculum, [and] gender issues in addictions . . . so there was that piece of it that brought me in. The other part that was a big seller for me was the whole sort of blended, you know, the web-based kind of technology, one because it's something I'm absolutely fascinated with, and in my current role I very much in the infrastructure part of developing e-learning,*

4.2 The topics discussed

In five webmeetings over a six month period, five complex topics were identified and discussed. The topic of the first meeting was predetermined, designed explicitly to be an overview of evidence and issues associated with sex, gender and substance use. A quiz at the start of the first meeting about gender differences in substance use, and a presentation on sex and gender differences in the experience of substance use problems served to evoke ideas which the community might tackle. In addition a report on sex and gender-based analysis as it applied to the substance use field was suggested as background reading [7]. By consensus at the end of this first session it was agreed that the second meeting be on the topic of addressing trauma/violence concerns, and that the rest be decided based on topics identified by community members via the discussion board and/or at the closing of each meeting.

During the subsequent meetings, three additional topics were decided upon, to make the full list of topics to be:

Session 1 - sex/ gender-based analysis, bringing girls and women's experiences and needs into focus

[7] *Applying a Sex/Gender/Diversity-based Analysis within the National Framework for Action to Reduce Harms associated with Alcohol and Other Drugs and Substances in Canada*, Canadian Centre on Substance Abuse, http://www.ccsa.ca/Resource%20Library/Sex%20Diversity%20Paper%20EN.pdf

Session 2 – integrating trauma and violence informed practice, in women's treatment

Session 3 - treatment, prevention and harm reduction with girls and young women

Session 4 - addressing the needs of pregnant women and mothers in the context of work on substance use prevention, harm reduction, treatment and policy making

Session 5 - gendered harm reduction principles, practice and policy

These issues - related to co-existing conditions (trauma), specific populations (young women, pregnant women), stigma and barriers to service (pregnant women and mothers) and treatment approaches or stances (harm reduction) - are central dilemmas for the addictions field. They reflect the breadth and nature of the needed response to girls' and women's substance use as a 'wicked problem'. Each of these issues is rich with significant, and commonly unacknowledged, gender-related factors, ideal for discussion in the virtual community and action beyond the community parameters. As Campbell and Ettore have stated in the opening of their book entitled *Gendering Addiction:*

> *"knowledge making practices in the drug research and treatment arena make it resistant to acknowledging the gendered, classed and racialized power differentials that structure the lives of drug-using women. Without such knowledge, we argue that what we need to know about women's specific needs will continue not to be known" (2011, p.1)*

Community participants were invited to suggest topics they would like to learn about/discuss, and materials or people who might contribute to the topics. In fact the participants responded (albeit positively) to ideas for what might be discussed; but did not proactively or independently generate topics or potential speakers. It was interesting that participants were content to be guided in the collective, virtual learning process over taking up the invitation to demonstrate initiative in generating topics as might be expected in a feminist participatory action research process.

Each of these topics emerged from important developments in the addictions field at large: developments which prompted the idea for the discussion topic,

influenced the views of those coming to the discussions, and made necessary the engaged format for the discussions to achieve the aim of provoking shifts in thinking and ideas for action. For all topics there existed multiple sources of evidence, substantial opportunity for contextualized application to practice and policy. As such, each meeting required preplanning and facilitation to achieve a successful learning experience.

As indicated the methods chapter, each session's agenda had three core components: the opportunity to introduce oneself and update each other on developments in one's workplace since the previous session; a component where various forms of evidence were presented, and a dialogic component.

4.2.1 Community meeting 1 - overview of sex/gender and substance use

What evidence was shared?

In the first session, a succinct overview of the sizable body of research evidence on sex and gender influences on girls' and women's substance use was shared. As such this session was weighted to a higher degree on consideration of academic evidence.

The overview included explanation of:

- the difference between sex differences (individual genetic and physiological constitutions including anatomy, physiology, genes and hormones) and gender influences (the socially prescribed and experienced dimensions of "femaleness" and "maleness" in a society (Johnson, J, Greaves & Repta 2007)
- prevalence of drug use (using cannabis, methamphetamine and benzodiazepines as examples) by girls and women from epidemiological survey research (Ahmad et al. 2008; British Columbia Ministry of Health Services 2004; Currie 2003; Health Canada 2003b)
- gender influences on motivations for use (Brecht et al. 2004)
- sex/gender factors in pathways to use (Adlaf & Paglia 2007; CASA 2003; Miller, CL et al. 2002)
- sex differences in the impact of use (NIAAA 2002; Tucker et al. 2004), and the

sex specific impacts of the intersections of substances (tobacco, alcohol and violence)

- health effects of substance use in pregnancy (CAMH 2008). There was not time to cover the gendered influences on substance use in pregnancy in this session.
- gender influences as portrayed in media and policy (Boyd 2004; Drug Policy Alliance 1999; Kilbourne 1999)
- diverse women's substance use using example of Aboriginal women and tobacco (Johnson, JL et al. 2004)
- gendered operation of stigma affecting access to care, and specifically the stigma directed to substance using mothers (Greaves et al. 2002)
- gender differences at treatment entry (Hernandez-Avila, Rounsaville & Kranzler 2004)
- gendered factors in the course/response to treatment (Grella et al. 2008)
- gender informed treatment principles (Royal College of Nursing July 2008) and the gender continuum of response (Feldman-Jacobs, Olukoya & Avni July 2005)
- women's voices (a excerpt from a women's treatment centre's client feedback)

What was the nature of the discussion or learning that emerged?

Several threads of discussion emerged in response to the quiz and the presentation on how sex and gender influences play out in a compelling way in the addictions field.

One thread concerned gender-specific barriers to treatment for women and the need to work in comprehensive and compassionate ways to bolster women's social supports and address and prevent gender-based violence.

> *I think it kind of relates back as well to that thing that we had in the quiz, about women taking on the patterns of their partners. And being very influenced by their partners. And I know that, in the FAS field, we've got some strong research showing that women who have children with FASD had partners who didn't want them to come and get help, and that's sort of like the violent situation that they were with partners who were controlling, right? And I think that we have to be very thoughtful about our approach so we're not adding more pressure to women but doing that, you know, combining support around substance use and violence and safety together.*

The need for awareness of, and action on, sex and gender in both prevention policy and in treatment options was brought in.

> *I just wanted us to also remember the whole prevention side and that it's really important for us to be aware of and supportive of initiatives to decrease access to alcohol. Health Canada has been working . . .on some low-risk drinking guidelines for Canadians. . . . And, of course, the guidelines [re what is low risk drinking by sex] are different numbers for men and women. And it's important information that we get out . . . .*

And it was recognized that gender-specific treatment was not generic treatment with some modifications, but instead treatment grounded in women's needs and preferences for care.

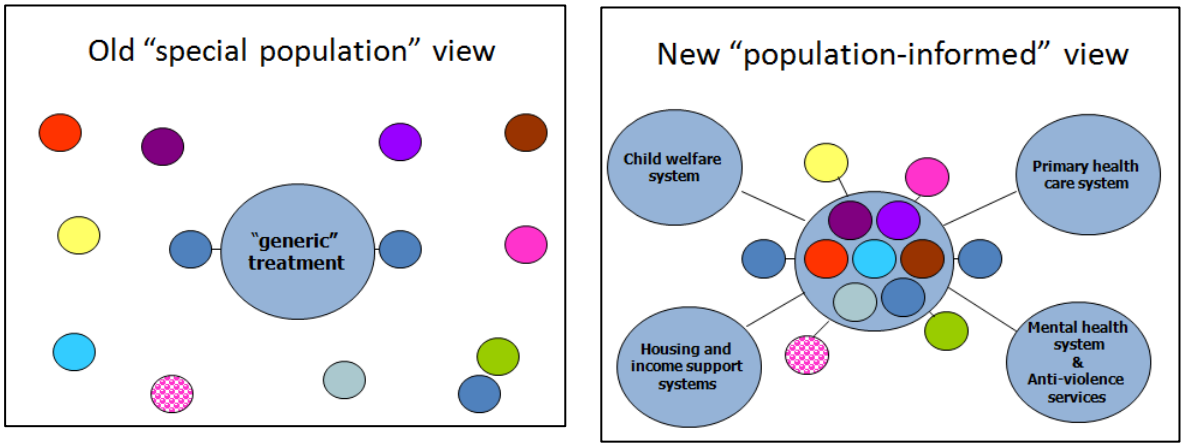
> *At Addiction Services in [names city in eastern Canada], we offer gender-specific programming and they're -- you know, based on a lot of study that was done, and information that was gathered, the focus groups, it was well established that women benefit more by being in a gender-specific program than a mixed program . . . we found that we needed to . . . seek out women-specific treatment options, programs that are -- or were written for women specifically as opposed to trying to convert a male program into working for our females. It just didn't work. t*

At the end of this meeting I described a view of systemic approaches to integrating gender that had been advanced in discussions with the National Treatment Strategy Working Group, and linked this to how the community might discuss action on gender-informed approaches in the substance use field.

> *[brought up 2 slides] We used to kind of organize our addiction systems to think that, you know, there's to be some kind of generic treatment, right? And then we had a few special populations we dealt, some -- some of which were linked directly to our generic treatment and some were just kind of floating around, outside [See left hand portion of Figure 3.1]. And I've been involved in the National Treatment Strategy Working Group over the past, you know, couple of years and we've come, you know, more to thinking about this kind of a view now, that we wouldn't assume there was some generic treatment but that all of our treatment, even within the core, would reflect understandings of gender and diversity[See right hand portion of Figure 3.1]. We would have some specialized gender-specific programs and that's these little circles outside -- just outside that core and yet diverse, you know, recognizing diversity there. And that all of this would be much more tied in to these other key systems of care, housing, income support, mental health, anti-violence, primary care, child welfare system, et cetera. So that, you know, our system of care would look entirely different. And I'm hoping that, over the course of the community, we can talk a little bit more about what does this mean from the people -- from the perspective*

of policy folks such as [names policy analyst participant], and [names 2 treatment providers who had just spoken], and others. What does it look like? -- you know, what do we need to do? -- people working within government, as well as service providers, as well as researchers, you know, to actually make this kind of a more population-informed or gendered view of the addictions system happen?

Figure 4-1 Slides showing gender-informed approach



The discussion of the importance of not seeing women as a special population, but instead to bring a gender informed lens to the whole system of addictions care (mainstreaming gender and having gender-specific options) was mentioned in the post community focus group as a helpful trigger to think about a gendered paradigm. In such a paradigm, women-centred care is not marginalized or simply "accommodated" as in the national treatment strategy, instead multiple lines of action are made visible. It is important to note that it was less the assembling and presentation of evidence on sex and gender differences in the experience of substance use, and instead the higher level synthesis of the implications for the structure of treatment system that was deemed helpful. In all it can be seen that this webmeeting catalysed important discussion threads and the opportunity for perspective shifts.

4.2.2 Community meeting 2 – trauma-informed practice

What evidence was shared?

At the second community, in the 'presentation of evidence' section of the meeting, a balance was struck between presentation of data from academic sources, the

perspectives of service providers, indigenous people's views, and service system developments. The presentation included:

- presentation of the data on the intersections of trauma, mental health and substance use issues (Brown, CG, Stewart & Larsen 2005; Chaim & Henderson March 17, 2009),
- consideration of gender specific barriers to treatment for women with trauma histories,
- presentation of published perspectives of service providers on defining and offering trauma-informed care (Dell & Fillmore 2007; Fillmore & Dell August 2000; van Wyck & Bradley 2007)
- Indigenous views on the importance of support for Aboriginal women who are at much greater risk of experiencing trauma and violence (Amnesty International October 2004; Chansonneuve 2007; Dell et al. 2009), and
- provision of an overview of a tiered service system response to women with trauma, mental health and substance use issues as later presented in the discussion guide (Tier 5 - the work of a women's treatment centre in Toronto; Tier 4 - the Seeking Safety model in practice in an outpatient context at the Victoria Women's Sexual Assault Centre in Toronto; Tier 3 - multi-faceted, harm-reduction oriented pregnancy outreach programs; Tier 2 - Trauma-informed brief interventions by counsellors; and Tier 1 - Peer support models such as the 16 Steps for Discovery and Empowerment) (Poole & Urquhart 2009)

At the end of the presentation of these sources, the following questions were posed: "Why do you think we have not attended to this important intersection with substance use to date?" and "What opportunities are there for building awareness/taking action on these intersections to improve the response for girls and women with substance use problems and related trauma and mental health concerns?"

What was the nature of the discussion or learning that emerged?

Participants discussed the lack of attention to trauma as central to women's substance use, and linked it to the lack of attention to gender-based analysis in the field.

I think that part of the reason that hasn't been attended to -- more fully before that was because the kind of trauma that women are more likely to experience is interpersonal trauma and particularly that very undermining type of trauma which is early childhood sexual abuse.

I think I'd also like to add to that what we're experiencing with our women is the minimalization that was talked about in the presentation, that many of these women think their lives of abuse and trauma are normal so they don't even know enough to identify it.

A couple of things kind of popped into my head as to why we have not attended to the intersection between trauma, violence, and substance abuse and I think part of that comes from ... not having gender-specific substance use type of intervention and so not really seeing a need to include trauma-informed practice. . . . I think we're really in a good place now to be able to weave or braid some of those pieces together and develop the women-specific substance use intervention that's very trauma-informed, and that encompasses mental health concerns and the whole list of women's health issues that have been left out of interventions in the past. So it's exciting, I think, to be in a new position and to kind of work it to fit with all this wonderful new information that we have.

Participants identified additional resources which might be of interest to others.

The other thing I appreciated was the model on Motivational Interviewing. And I'm not certain if you're aware, the University of New Mexico has produced a manual on Native Motivational Interviewing techniques. [weblink to this manual was added to website]

The issue of tailoring trauma-informed care for different contexts was discussed. The following excerpt discusses the needs of criminalized women with substance use and trauma concerns.

And in fact it is a problem in corrections in terms of kind of forcing women to deal with issues such as trauma in a place that may not be all that safe for them to do so. . . And that in some ways, being trauma-informed in a correctional centre is perhaps respecting that pacing more than ever and just figuring out a way of talking about change without having to make it be as big a therapeutic change perhaps, but a more pragmatic change that could be like learning coping strategies or whatever, that could be quite practically applied within the context of a correctional system and much more of a link with community-based services like Seeking Safety groups and whatever, being made

The need to address trauma concerns of young women was mentioned, and this participant suggested collective examination by the community of material and approaches. (This discussion led to identifying girls' issues as the topic for the following meeting).

I'm just looking through some of the resources that were suggested and wondering if a next step would be to sort those resources into the populations that they're appropriate for? Just looking through this briefly, they look very adult-made so wondering if maybe if we can group together, we can look at youth-specific resources that help to deliver in the treatment centres, or in outpatient centres or whatever?

The idea of attending to coexisting substance use and trauma issues by "mainstreaming" attention throughout the field, not only through providing gender-specific services was raised.

And I think the point we've been trying to make today, as well, is that we need both gender-specific and also a kind of larger mainstreaming of gender issues and being gender informed, including thinking about trauma in all we do so that -- I don't want people to think that the only place women are going to be treated is in gender-specific programs 'cause I don't think that's either necessary or likely, right? But that we can be sensitive to gender and diversity issues within the context of our general outpatient counseling and harm reduction services and detox services, prevention services, self-help services, as well as having some places where there is the opportunity to do gender-specific work that is safe and addresses the connections.

I noted:

. . . people like [named participant] -- while we were doing the National Treatment Strategy document, will remember how frustrated I get when we call women a 'special population' and how long I had to argue to get people to not use that word [special] in that document. And hopefully that's what we're starting to get to, that this is just a reality for most women with substance use problems, that there are trauma issues and that we just need to take that into account in what we do and not see it as a special problem that we can just deal with in a really narrow way, but that we embed it in everything we do.

The material considered in this community meeting and the learning arising from the discussions can be found in Appendix 3 and at http://bccewh.bc.ca/category/post/trauma-violence-mental-health/ as the *Gendering the National Framework Series, Volume 1: Trauma Informed Approaches to Addictions Treatment*. The outline for discussion guides were based on the interests and direction of discussions in these the first two community meetings. As such all four discussion guides include:

- a presentation of evidence from the literature about the issues involved and the complexity of the linkage among issues, as well as evidence-informed practices
- descriptive examples of how this evidence is being brought into practice and policy by agencies across Canada, including weblinks to all these program

examples

- questions to promote further reflection on the issues and possible action(s), on the part of direct service providers, leaders and system planners, in their specific contexts

For in these first two sessions it was clear that participants had not heretofore seen this evidence assembled in a coherent whole, and appreciated the opportunity to see a sex and gender lens applied. In fact they were moved to comment on how the field was operating in a gender blind way. Secondly they appreciated the exposure to the ways in which the evidence had been applied into practice and to the ways these practice examples fit into a system view (in this case the tiers of the substance use field identified in the national treatment strategy). In this way the sessions did not get mired in discussion of barriers to movement on women-centred care, rather options for action that were in place or that might be put in place were offered. Attention to diverse needs, and requisite tailoring for different sub-groups of women and girls were raised. The use of questions about the visibility of gendered approaches, and possible strategic changes in practice and policy was effective in prompting dialogue and collective synthesis.

4.2.3 Community meeting 3 – Approaches with girls

What evidence was shared?

For this session, a 2-page backgrounder on applying sex and gender-based analysis to youth treatment was provided prior to the meeting. It listed key issues for substance-using girls/young women in one column, and the potential implications for treatment in a second column. Also provided to community participants (posted on the web workspace) was a list of web-based reports on youth and substance use issues (12 links), reports on girl-specific research and programming (6 links) and general adolescent treatment, harm reduction and prevention programs (11 links). In addition, a search was done of academic databases on treatment, prevention and harm reduction interventions designed for girls and young women, and the abstracts posted in the web workspace.

The presentation in the meeting focussed on work done by one of the community participants to bring a gendered approach to treatment of solvent (inhalant) abuse for Aboriginal teen girls and boys. She presented the adaptations made to youth solvent abuse treatment programming based on national data collection that showed different risks for the girls and boys presenting for treatment. Boys and girls are admitted in gender-specific cycles and the gender-specific programming is tailored by gender. For boys - who are more likely to cause injury to others - the group interventions are centred around the development of empathy, emotional intelligence, and prevention of bullying. For girls - who are more likely to have make suicide attempts and to have identified sexual abuse - the group interventions have more emphasis on healing and empowerment. The presentation by the community participant who is leading this work nationally, illustrated how, when they made the programming gender-specific for girls and boys with solvent abuse problems, the time participants took to settle into the treatment program was reduced, incidents were lower, treatment drop out reduced, client satisfaction increased and therapeutic alliance increased.

What was the nature of the discussion or learning that emerged?

The backgrounder elicited extended discussion of the how the choice of, patterns of and trends in young women's substance use are not well known; how the health-related concerns of young women with substance use problems are not visible; and how as a result gender-specific treatment for girls and young women is not well developed:

> *And then the other area that, you know, I think are really important for us to be thinking about . . . support during important life transitions . . . that whole issue around connection and relational connection that seems to have come up consistently in the literature as being something much more important for girls and young women. And the Formative Years report was really very clear on that -- that particular connection.*

> *I think that it's -- it's a process. Like, I think, you know, we've made some gains, I think. . . in treatment in [names province] to be more sensitive to special issues for women. But I think that, you know, the gains in that area have come more in the adult treatment spectrum and more around the pregnancy issue . . . I think that's just another whole sensitizing piece for our staff, is, you know, what could we be thinking about and doing different for young women in treatment and young men, in terms of how we structure programs. And I just think we're just really at the beginning stages of even, you know, thinking and doing much around that.*

In response to the gender-specific treatment for Aboriginal youth, the discussion centred on responsiveness to gender differences, and the challenges of getting systems to accept gender specific work.

> *And it was [in a program in Alberta that offered gender specific groups] . . . kind of interesting that the program topics weren't as different but the actual, you know, things that went on when the conversation was opened amongst the people in the program about what, you know, what they needed or what was useful to them, was -- was very different by gender. And it sounds, that that's been somewhat of a similar thing in that, if we -- in your case -- if programs were able to kind of see it that way, that we're not asking you to completely revolutionize everything, to be totally different, but that more that you're creating the space for, you know, the processing of it to be different, and not to have to worry, as [another participant] said, 'taking care' of the other gender or being triggered by the other gender, or whatever, that -- that might make it more possible for programs to see -- you know, to think about doing gender-specific work.*

> *And I tell you, when I first said to them, "I'm going to do this," [make the treatment gender specific] some people in the room said to me, "That's not normal." (laughs) . . . And certainly my retort was, you know, 'being in youth treatment is not normal either." But, I mean, twelve years now and certainly the whole group has embraced the idea wholeheartedly. In fact, when a new treatment centre is starting up, usually the group goes, "Oh, don't do it, don't do it, don't do the co-ed!"*

At the same time participants had ideas for how to shift the balance, to support the reflexivity and agency of service providers, funders and researchers.

> *And, you know, I really feel that a big part of -- when -- when people say, you know, our youth treatment centres don't attend to gender, I think a big part of that is policy. Because many of the treatment centres, the way they're funded, their structure is based on their funding agreements. And it may not be that they haven't thought about the idea of gender-specificity but it may just be that, you know, that has been the way they've been funded for so long and they don't know a way to get around it.*

> *I wonder how much of that [the presenter] speaks to -- is that understanding amongst those who work in the system . . . And I wonder how much do we have to -- and how do we inform the treatment providers, those who are in the system, to kind of examine -- you kind of have to examine your own life and your own beliefs, right? Of all of that, and that -- at least in our work with the women, that -- that seems to be kind of the foundational component.*

That's what they did with the CIHR (IGH) with research around saying, you know, "It's better science with sex and gender." That's the name of the document, right? Just to try and convince the CIHR that this is not something we're asking you to tack on, this is something that will make your science better.

The presentation of personal action by this treatment provider on gender informed practice served well to elicit questions and promote reflection in this session. That the example was one from Aboriginal treatment was compelling, as often the stereotype in Canada is that Aboriginal people are not interested in gendered approaches (Green, J 2007) and that the treatment system for Aboriginal people is less advanced than that serving non-Aboriginal people (Chansonneuve 2007). This topic, and the way it was presented, served to evoke important discussion about the evidence for gender-specific and culturally-specific treatment for Indigenous girls and boys, the ease of implementation of gender-informed approaches, the positive outcomes associated with gender-specific approaches and the actual and potential strength of service providers to defy pressure to not attend to gender.

Just wanted to thank you, [to the participant who led the discussion] for the presentation. Excellent. And the discussion. You know, I think the -- the science, as you've said, Nancy, is so critical in making the argument.

And then you're -- and you're right. In the groups, it's not necessarily that the subject matter is different, but the way it rolls out is completely different. And over time our kids have consistently told us, that they prefer the gender-specific treatment.

participant who led the discussion

The material considered in this community meeting and the learnings arising from the discussions can be found in Appendix 3 and at http://bccewh.bc.ca/category/post/trauma-violence-mental-health/ as Gendering the National Framework Series, Volume 2: Girl-Centred Approaches to Prevention, Harm Reduction, and Treatment.

4.2.4 Community meeting 4 – pregnancy, mothering and substance

What evidence was shared?

Participants were more likely to be acquainted with the issues surrounding pregnancy, mothering and substance use, as considerable attention had been brought to this issue in Canada in the years leading up to this study. In fact, substance use in pregnancy could be said to be the one aspect of women's substance use where considerable attention had been focussed (Greaves & Poole 2007), albeit in more of a gender exploitative than a gender transformative way. Often fetus-centred versus women-centred approaches have characterised fetal alcohol spectrum disorder (FASD) prevention interventions (Greaves, Poole & Cormier 2002). However in the years immediately prior to this study, women's health promotion experts, maternity care specialists and substance use researchers had contributed greatly to the FASD field, bringing attention to prevention of FASD as a women's health concern (Drabble et al. 2011). However media and policy discourses still commonly construct children's interests as competing with, or subsuming the interests of mothers (Boyd & Marcellus 2007; Greaves et al. 2004; Marsden February 2, 2014; Poole & Greaves 2013); and mothers rights to respect, treatment and parent commonly denied (Greaves et al. 2004; Paltrow & Flavin 2013; Reid, Greaves & Poole 2008; Young Women United 2014).

Due to participants' likely familiarity with the issue of mothering and substance use, yet the pervasive stigma and small gains towards programming for pregnant women and new mothers in Canada, prior to the fourth meeting participants were encouraged to read a report which profiled a model of positive response to pregnant women and new mothers at risk of having a child affected by Fetal Alcohol Spectrum Disorder (FASD). This document had been prepared in consultation with researchers, service providers, and government policy analysts across Canada, and funded by the Public Health Agency of Canada http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/publications/cp-pc/index-eng.php. The document provides a conceptual model for prevention of FASD by working at multiple levels with women at different levels of risk – from awareness building with all society, to brief discussion about alcohol with all women by physicians, to holistic, low-barrier programming for women who are finding it difficult to stop drinking in pregnancy, and postpartum support for new mothers and their children where alcohol remains an issue. The report provides

information on the existing, albeit limited, examples of programming in Canada that work at these four levels of prevention and support. The suggested pre-reading of this report was intended spark discussion of the conceptual use of research as was realized in the report, as well as reflection on the actions treatment and prevention specialists had been taking. In this way, it was hoped that the tone of the virtual community meeting might go beyond a revisiting of the tremendous challenges in overcoming the barriers facing pregnant women and mothers, to consider evidence-informed strategic action(s).

A representative of a women's treatment program in Toronto, the Jean Tweed Centre, which had added components for mothers with substance use problems and their children was invited to make a presentation on the background and implementation of that programming.

What was the nature of the discussion or learning that emerged?

Inspired by the presentation from the Jean Tweed Treatment Centre on how they have adjusted their programming to address the needs of mothers, the discussion centred on models for addressing parenting needs, such as:

continuity of support

> *all of these mothers are in the Pathways program and have a Pathways outreach worker. So that Pathways outreach worker follows them through the entire Mom and Kids program and then they follow them through after . . . So many times people just go to programs and think that, within three weeks, suddenly, they're fixed, everything should be good. No. We have a -- most of the women that are finished with the Mom and Kids program work with their Pathways counselor for, like, a year after, or six months, a year, year and a half.*

working with, not against child welfare

> *So when I came to this work and took this job, you know, I very soon realized, you know, these women have children and Child Welfare is in their life and we as addiction service providers need to not keep our head in the sand and not ask these questions [about children's needs and safety]. Because so many times we just don't ask the question. And what we found very early on is that, if we approached Child Welfare in a supportive way and not an accusatory way, and said, "You know, we're on the same page, we both want the same thing, we both want to help these families to keep children safe. Let's do this together with the moms."*

not focussing only on substance use

One of the challenges we've had in BC, I guess, is really helping Child Welfare to get to two things. One, to get to the idea that substance use isn't the main change that has to be made. It's clearly one of the changes but that the parenting support, the housing support, all those other -- mental health support, et cetera, freedom from violence against -- you know, with difficult partners and -- and those kinds of things. It's been a bit challenging sometimes to get all those things on the table and to have the holistic discussion rather than focusing on the substance use, because so many Child Welfare workers seem to feel like that's the problem or that's the most changeable

not focussing on treatment as the only avenue for improvement

helping them [child welfare workers] see that reductions in use and moving, as you say, along the scale from pre-contemplation to contemplation and preparation as good outcomes and not necessarily seeing that getting to quote 'treatment' is -- is really -- you know, may not be where this woman is ready to go at this time

reaching out, and addressing barriers rather than expecting mothers to come to treatment

A number of years ago, we were involved in the North . . . took the initiative to develop a mobile women's treatment centre. So they actually brought First Nations women from nine communities into a central community and used the treatment dollars and had the women in treatment there and it was very successful And I think their lead time was three months, and that was very important because, for some women it meant convincing their husbands to let them go; for some, it meant organizing child care; and one of the earlier comments from your women, for the members on the panel today, that I thought -- really struck a chord for me, was that many of our women are afraid to go to treatment because they have to put their children in care, and they're frightened, and they will resist treatment. And so what the coordinator did was she made sure that, if a woman had to pay for a babysitter, that those dollars were provided and a woman could choose her own sitter. And this was also important in some of the communities where sexual abuse is a real danger for a mom, and being able to choose her own childcare worker and pay for that was really important for her coming to treatment.

With these examples it can be seen that the goal of sparking reflection on approaches to action was achieved. The material considered in this community meeting and the learning arising from the discussions can be found a in Appendix 3 and at http://bccewh.bc.ca/category/post/trauma-violence-mental-health/ as Gendering the National Framework Series, Volume 3 Mothering and Substance Use: Approaches to Prevention, Harm Reduction and Treatment. This discussion guide has been highly accessed, and the four-level model of support for mothers which is presented within it, has been widely recognized, due to ongoing work by members of this study's

community who have worked with me post community, along with a broader group of researchers, service providers, policy analysts, and birth mothers who meet using in a similar ,virtual community format as part of the CanFASD Research Network. See www.canfasd.ca/prevention-from-a-womens-health-determinants-perspective/

4.2.5 Community meeting 5 - women-centred harm reduction

What evidence was shared?

A discussion paper on women-centered harm reduction was shared prior to the online community meeting, as a foundation for the webmeeting discussions. The document provided brief analysis and lists of articles and reports related to ten facets of harm reduction, designed to address the needs of girls and women. These ten areas included 1) pregnancy, 2) mothering, 3) housing, 4) HIV, 5) violence, 6) engagement through low threshold services,7) access to primary care and addiction services, 8) sex work, 9) harms related to drug policies and related health and social policies, and 10) reducing harms for criminalized women. The backgrounder was built upon the novel thinking of leading Canadian advocates of women-centred harm reduction from the Canadian Harm Reduction Network, the Canadian Drug Policy Coalition and the BC Centre of Excellence for Women's Health as we prepared a presentation for at International Harm Reduction Association conference in Barcelona in 2008 (Poole et al. May 13, 2008). Normally harm reduction is focussed on reducing harms associated with injection drug use and HIV transmission. In this case, the scope of harm reduction as relevant for girls and women was broadened, to view the harms associated with substance use from these ten additional facets. A selection of issues and practices from the over fifty reports and articles highlighted in the discussion paper include:

- the significant barriers to primary care women drug users face, as identified by women drug users in Vancouver entitled "Me I'm living it (VANDU Women CARE Team 2009). A key principle of harm reduction is the involvement of drug users in defining their own needs.
- how contested harm reduction approaches are when applied to pregnant women who use substances. A UN report (UNODC 2004) identified how ill formed and punitive policies for pregnant and mothering women who use substances result

in a lack of access to accurate information, hostility from health care providers and police, lack of access to prenatal care, diet, harm reduction services, drug treatment and other forms of support, and increased child apprehension by state authorities.

- the need to recognize and affirm the strategies employed by heroin-using mothers to reduce harm to their children (Richter & Bammer 2000)
- the over representation of Aboriginal and sexual minority girls among marginalized and street-involved youth: a BC report profiling street involved you found over half were of Aboriginal descent and lesbian, bisexual and questioning teens were over-represented (Smith, A et al. 2007). As such policy frameworks must be attentive to social effects of these differences, especially where discrimination and disenfranchisement discourage or eliminate access to services.
- how lack of housing is a significant harm affecting the health of women and girls who use substances (Elifson, Sterk & Theall 2007; Khandor & Mason 2007)
- how income insecurity is related to sex work and substance use: Dalla (2003) found that less than half of the street-level sex workers in her research entered sex work to support an existing drug habit. Rather, they were propelled into street level work first by financial need.
- the need for frameworks for prevention and care to acknowledge the need for connections between programs and services including strong legal aid systems, sexual and reproductive health services, HIV and HCV prevention services, and domestic violence and sexual assault prevention and recovery programs (Pinkham & Malinowska-Sempruch 2007; Shannon et al. 2008).
- the impact of drug policies on women and families in the USA , especially the increasingly high rate of incarceration of women for drug offenses (Lapidus et al. 2005) and approaches to reducing harm for criminalized women (Acoose et al. 2009).

As such, a very wide, novel and gendered view of harm reduction was covered in this virtual community meeting. The presentation was based on considerable evidence from local and international research focussing on the perspectives of drug

using women, and from policy reports authored by national and international policy bodies such as the United Nations.

What was the nature of the discussion and learning that emerged?

This discussion took place in the context of some successful developments towards integrating harm reduction approaches within the addiction field. Those working from the public health view of substance use in Vancouver had succeeded in prompting public dialogue on harm reduction approaches that involved researchers, practitioners, governments, drug users, parents and interested citizens who shared a concern for the health of drug users in Vancouver (Government of British Columbia 2005; MacPherson 2001). This process modelled a multi-sectoral approach (similar to the virtual community) and to some degree vindicated a harm reducing, public health stance towards problematic substance use in BC and beyond, yet at the same time those advocating the moral and disease models of addiction actively resist(ed) the discourse. Notably the needs of women with illicit drug problems were not highlighted in the course of this otherwise progressive achievement, even though the drug user network (VANDU) had involvement by women and ultimately a community-based research team of women drug users. (Salmon, A & VANDU Women CARE Team 2007; VANDU Women CARE Team 2009).

Sustained discussion of a number of issues took place, as well as questioning, and sharing of links. A few examples are provided here.

Giving voice to people with substance use problems to define the type of support they see as helpful was discussed. Examples of the three types of voices which were mentioned as important to be included were:

voices of parents of children with substance use problems:	*In Vancouver, you know, we've had a little bit of luck with that in two ways. And one is with a group of, you know, harm reduction advocates holding public dialogues on some of the issues, right? But one of the things that's really, I think, made those dialogues work well, . . . is that some parents of kids who have drug problems have really stood with us on this one. And have really advocated for this kind of an approach, recognizing that the treatment system doesn't really -- isn't really that helpful to them as parents with kids with problems, unless there is, you know, it is tiered to include harm reduction along the way. .*

voices of women accessing outreach counselling for pregnant women:	*And a lot of the women have said, you know, in that evaluation, was really, you know, 'the most important thing to me was that I was listened to'. So the service user was the driver of what they wanted, and the people who were delivering that program actually don't prescribe an individual treatment plan but actually help women think through where they're at. . . That what they really need is a connection to the system that's kindly, compassionate, supportive, and helps them identify what is Step 1? Is it getting housing that I can hang on to? Is it – whatever*
voices of middle class women who were birth mothers of children affected by FASD:	*the idea was that they were going to create some kind of pamphlet that would help middle-class women who were drinking prior to pregnancy and during pregnancy, you know, grapple with some of the issues. And it was really interesting because they came to the table and I said, "Well, you know, how do you want to approach this?" And the first thing they said to me was, "Why don't you tell us about all the harms associated with alcohol use, not just the ones in pregnancy? And let's put together something that's a bit broader than just pregnancy, because I'm not sure it's going to be a big sell if we focus on pregnancy alone." . . . And I thought it was a really interesting statement about harm reduction in some ways, was because that was what they felt might help women more directly, . . was related to breast cancer, that might be a bigger deterrent, even, than thinking about harming their fetus.. [Linkage to pamphlet online was made in the chat function]*

Pregnancy and harm reduction was discussed at length:

A participant who is a professor of sociology called for ideas of pregnancy and harm reduction	*One of the -- one of the difficulties around the public dialogue about harm reduction is that -- as you say, there have been inroads, and there have been some really good processes put in place where -- it's sort of generating dialogue. But one of the places that I find the most problematic is when you move into the discussion, the public discussion about harm reduction and gender and pregnancy. It'd be really interesting to hear about any projects anybody knows about, trying to sort of move that dialogue along. I mean, I say this because I -- even in teaching sociology, I, you know, try to get students to think more critically about this issue and, you know, it's the one place where I get a lot of pushback from students, even around the question of alcohol and pregnancy*
One example of harm reduction for service providers working with pregnant women was offered by me in response	*initially, when we put that forth, people would say "Oh my god, are you recommending harm reduction in pregnancy? Oh my god!". . . . it's just been such an interesting thing to reason through with them. "Well, what has been your experience with women when they come for help in pregnancy? How has the abstinence message gone over for the ones who are struggling with substance use issues?" And they said, "Well, it doesn't go over." And we say, "Well, exactly our point. So how do we break it down into a place where you are supporting her, wherever she's ready," as [names participant] said initially, "like, starting where she's at as opposed to, you know, Step 10, which may be abstinence." . . and by teaching the actual skills and processes of having those discussions. I feel like that has been what's tipped the balance in BC, amongst many of the providers, toward a harm-reduction oriented approach.*

Points were raised over the course of the webmeeting on the importance of understanding different levels of substance use, as critical to generating responses that supported people's efforts to reduce harms, not only abstain from substances

I think that frame that you talked about earlier, too, [named participant], about substance use, problem substance use, and addiction is a helpful frame, too, for people to get it, that not all substance use is addiction and requiring abstinence, by any means. That there's a continuum. And I often use that same continuum, [names another participant], around mental illness, too, talking about mental health, mental ill health, right, and then mental illness, right?

It's particularly important in alcohol and that's the focus of my work so we know that, when it comes to the bell curve around alcohol use in the population, only about five per cent of the population or maybe ten per cent at the outside are truly addicted. But if you think of the rest of the bell curve, all the problems and costs are generated by the people in the middle of the bell curve. .

The need for taking on misperceptions, proactively having dialogue about harm reduction was discussed.

> *when I think of the most heated discussions I've ever had about harm reduction with people, it's usually because their definition is so narrow. So, usually to me, either needle-exchange or methadone. But I once read a definition, and I'm just trying to find it here, where it talked about harm reduction as 'mechanisms and policies that reduce risk not only to the individual user but to the surrounding family and community.' And I thought if -- in -- you know, publications and that, if the definition is a broader definition that's more palatable and we, you know, in all our different organizations work to make that happen.*

Quite an in depth discussion took place on how inequities are linked to substance use, mental health concerns and harm reduction. A few brief excerpts:

One participant sees how gendered health inequities are not well understood

When I'm talking about it, and thinking of women, I'm thinking of health and equality and how that links to mental health but I think, for the most part, that broad understanding in how inequalities and so forth fit into there, you know, that's not what we're always talking about. I don't think people are on the same page at all, and maybe that's an area, when we are speaking about girls and women, I mean, it's so clear, those inequities and so forth, and how that all fits together. And that's a much -- I think more accurate understanding.

Another participant sees how in public health fora where social determinants of health and health inequities are being discussed, the link to gender and to harm

And I think that's certainly something – [names participant] and I saw a lot of great discussion of at the Canadian Public Health Association conference recently, [there] was just really a tremendous interest on the part of people working in very different fields, as to the question of how do we reduce inequities. And I think that's a -- it's

reduction can be made	*a great lens in, to thinking about harm reduction*
Another participant sees how harm reduction can be linked to issues of inequities that public health advocates are already concerned with, so there are benefits to transdisciplinary and cross-sector discussion and action	*You just mentioned using inequities and so on as a lens into -- or a way into some other work. In order to get the Toronto Drug Strategy, there was no official definition of harm reduction outside of Public Health, except in the Homelessness Task Force. And because city council in Toronto had endorsed the Homelessness Task Force report, the Public Health folks and others in the City of Toronto were then able to capitalize on that and bring it over into developing a drug strategy.*

This discussion of inequities led to the following four-part exchange that illustrates how learning together across different roles – academic, service provider, system planner - was enacted in this community.

academic	*I just want to go back to the discussion about social context and use, and social determinants of health for a moment. One of the things that I find interesting about the current context overall is that it is a neo-liberal context, which tends to really individualize social problems, and so there's kind of a framework or a filter through which sort of any kind of problem is shoved and so that it comes out at the other end as a -- as a, you know, personality issue or a mental health issue or whatever. And I -- you know, I think that there's a role for harm reduction, as we were talking about earlier, for challenging those kinds of very dominant ideas. But one of the concerns I always have, or one of the anxieties I always have about harm reduction discourses is their own tendency to focus on the individual and to incite healthy choices by the individual in a contextless way, so that what happens is people become responsible for their own health in new and interesting ways that result in more stigma and more blaming. So it's -- it's a -- always a caution I have about these kinds of discussions.*
Service provider	*what you're talking about, I'm just trying to wrap my head around and I'm not doing a good job of it (laughter). Can you say some more about that, because I am -- you know, I think about sort of the front-line work and you've got a person sitting in front of you, and so just speak a little bit more about that, what you're talking about in terms of this -- not just focusing on that individual, but when you were talking about the systemic way, or the systematic way of engaging in care.*
me as researcher/ evaluator with a program	*Well, I think, you know, one of the best examples is in your organization is [names outreach program for mothers with substance use problems] I mean, initially, it was going to be a feeder into treatment. We were going to find these women who were not accessing treatment and who had substance use problems and pregnancy and we were going to help them get to [names treatment centre]. But, in fact, it hasn't really done that, but it's been highly effective. Because a lot of the women who have accessed [names the outreach program] have no intention of going to [names the treatment program], right? It's kind of building in a place in the system where people can come to it and relate to it in the way that they want.*
policy analyst	*And we've had some really interesting discussions here [names province], you know, in the act of creating this group of advocates, you know, it's really*

> *called upon us to have these discussions with ourselves. I mean, where do we come down on decriminalization, and, you know, legalization, et cetera. So it's been kind of fun to have some of the debates, because it helps all of us to clarify to what -- what we need to do at this point, not only in the treatment system but at the policy level as well. And I think that's the greatest gift that the harm reduction world has given us in some ways, is that it's forced a dialogue on the policy level and the public discourse, as [names participant] studying, in ways that, you know, the addictions field never had before. We were really under the radar and there didn't used to be much in the news at all about us until, you know, until we started to be at this place of talking about harm reduction.*

Harm reduction remains the most ideologically driven area of the addictions field and the area where there is the least research, gender-based analysis and gender-informed action. Clearly in this vCoP conversation, participants were grappling with the paradigm of harm reduction overall, not fully engaging with the gendered implications of the paradigm for girls and women. However the discussion was rich, with more extended exchange among participants on key issues. The quality of the discussion may be related to participants being more accustomed to the webmeeting format, better acquainted with each other, and/or interested in the harm reduction paradigm. The nature of their participation, inclusion, reflexivity, and learning as well as the influence of the virtual context will be considered in depth in the next three chapters. It is clear that all these elements of knowledge translation, participation, learning and distributed (virtual) involvement were in play.

The material considered in this community meeting and the learning arising from the discussions can be found in Appendix 3 and at http://bccewh.bc.ca/category/post/trauma-violence-mental-health/ as the *Gendering the National Framework Series, Volume 4: Women-Centred Harm Reduction* .

4.3 Post community reflection on the impact of the virtual community

Eight months after the community of inquiry, participants were invited to participate in a virtual focus group to reflect on their participation and its influence on their subsequent work. The focus group was held on March 3, 2010. Nine participants attended who reflected the range of frontline service provision, policy, education, and research mix that the community had been successful in attracting.

In the focus group, participants spoke again of **the draw** for them to participate. They most often mentioned the draw of working in a virtual context – most had not had experience in working virtually, and they saw the benefit for themselves in terms of having increased access to learning, and also in utilizing it in turn, in their work with communities. Interestingly another draw was having access to researchers and to the program developers who presented to the community, from whom they could learn.

> *I wanted to add to what the other ladies are saying, that your reputation Nancy, also attracted me. The work that you have done in the past, your research was certainly something I wanted to know more about and this was a wonderful opportunity, and not being able to travel out to – I could never have gotten to this many meetings in the last year or workshops and have the opportunity to gain this much knowledge and information, and also being able to hear from women across the country about programs that they're involved with in such an immediate and intimate way, where I can ask personal questions is really a helpful format for me.*

It is of note that the community had been positioned as an egalitarian one where each participant had the opportunity to identify topics, provide ideas for material to discuss, and lead discussions. In fact when the opportunities were offered, participants engaged in identification of topics within the meetings, yet were more likely to defer to me for the bulk of the facilitation, the assembling of relevant literature, and identification of promising programs and policy.

Two participants describe the **impact on their overall perspective** related to women-centred approaches.

In gaining a gendered perspective, a participant came to understand the need for attending to physical health of women offenders, and to find a health care provider who could do so in a sensitive way	*One of the things that changed my perspective was just maybe really – you fine-tuned my hearing, you made me pay attention, you made me listen to something that I hadn't been paying attention to. And in the end what we did was we went on a search for a female physician who would be willing to come out to the jail and actually do family life education, answer their questions about birth control, further questions about infectious disease, from a physician's perspective, and that there were many ladies, and again it's with their special challenges we had to work really hard to find a physician who was not only willing but also had the demeanour that we needed to work with these ladies. These are women who have survived against impossible odds and I didn't need a tough doctor, I needed a really gentle female physician and fortunately was able find one, and she's just doing the most wonderful work with women. So I give thanks to you for that, for just waking me up and making me look at things in a little different way.*

A participant describes a moment that was a trigger for her to think about gendered approaches,	*it might seem really simplistic but it was really important for me, and it was around the fact that originally I had been writing about "special" populations, and I remember in one of our meetings, I think it was you Nancy who talked about "specific" populations, and I don't exactly ,but that was a huge shift for me, as a, you know, I don't even know exactly how to articulate it yet because I haven't, you know, thought about it for a while now, but just it somehow equalized things in some ways for me and even just that very slight word shift . . But to move off special as somehow . . . when I would think about special populations and maybe I thought about them as delicate, and maybe if thinking about specific populations, maybe I came out of that conversation or that dialogue just thinking more around the resiliency and the strengths and those kinds of things. I don't know, but that just was one of those lovely moments in this that was good learning for me.*

The community also **influenced participants' work** at various levels, including educating co-workers about structural improvements made, identifying work to tailor treatment, linking women's use of alcohol in pregnancy into larger work on building community alcohol policy, and linking the local work on women's substance to the need for broader system level strategies.

Educating co-workers, prompting structural improvements in service delivery	*I shared . . . what I learned each week, and as a result of that we were able to continue to work together to try to get more people involved in Women's Services. We hired a clinical therapist, we also had the adolescent workers join us and to look at how we can work together with women and girls, and adolescents and youth . . . and actually it's really nice to be involved in this today because it gets me thinking that I really need to strive to bring the information forward to others in the agency, and particularly the structural changes so that we can continue to do the specific work that needs to be done for each population for women and girls.*
Presenting on gendered policy approaches at conferences, to invite thinking and action in broader fora	*[named participant] and I have been doing a fair bit of work around trying to think about how you fit the issue of prevention of FASD into larger alcohol policy strategies. And you know, we've been thinking about it in various ways and so far largely have done things like spoken to the issue at CCSA's conference in Halifax last year . . . and we are about to again insert that in a discussion at the Canadian Public Health Association Conference in June in Toronto. So . . . at this point . . . we haven't actually been able to shift anything yet, but you know I think even raising the question is a form of action in lots of ways. . . .*
Linking small service level changes to larger systemic strategies is made possible when face-to-face and virtual presentations are made that involve the North	*I mean it's funny how I find in the work you end up working on a variety of different levels and having you come to try to work at that level [at the community level in the north of Canada as well as virtually] is fantastic for us because in our prevention work that we're doing we have plenty of opportunities to take action - and to implement this work that's sort of at a higher policy systems level, we don't always get those opportunities, so building*

on the smaller things but yet the big things that we're doing . . .

Participants mentioned how important it is to keep the kind of dialogue offered going. And how tough it is to keep going without this kind of support in current restrictive ideological and funding environments:

Important to keep dialogue going, is appreciated	*Yes, I was just going to say that I think that keeping the dialogue going is critical. I know for the population of women that we are working with they don't have services available to them, whether it's housing, whether it's a women's shelter, poverty is an issue, HIV, just their basic survival are all challenged and they don't have the special privileges that they need. So I'm so pleased that you've entered into this war and that you're bring us with you.*
Dialogue gives participants a boost, when improvements for women with substance use problems are slow to be realized.	*To me it just feels like a battle because we're fighting every day for the women and often you know coming up with really poor resources for them, so maybe that's just what we feel like from our side.* *Yeah, it does feel a bit like a war sometimes, doesn't it? And that's kind of why I'm trying to reframe it as a dialogic possibility, that you know by bringing different kinds of people together and across the country is to really give us all some boost, I guess before us going forward to take on the system in some ways, so it does have a bit of that sense of girding the troops! (laughs)*
Ongoing dialogue has the potential to help keep voices heard so that gains are maintained at least.	*So I'm a little worried about what's going to come, and when we fought so hard to get those things for women. And so I think this group and this dialogue will present a voice for all women, but I think hopefully a powerful voice, that we continue to at least maintain what we have and hopefully obtain more in the future. But I am very worried about where we're going.*
Connection is what we advocate to support women, and it underlines that it is important for workers as well	*I think that being a part of this validates a whole lot in terms of what I think about Women's Services in terms of about the importance of connecting with others, and certainly heightened, if it could actually do that, and it did in many ways, heightened my interest to stay connected.*

Finally gratitude was expressed for the opportunity provided by the community, to reduce isolation, to inspire and support the need for evidence to underpin action.

> *I guess I was just wanting to share how grateful I am for this kind of forum because -- in really thinking about the barriers that we have in bringing these ideas into practice, I think for many -- for myself often it feels like I'm working to bring these ideas in but, because it's a field that's traditionally been not gender informed and not trauma informed, it often feels like I'm working in isolation so I think it's so important for me to have access to these ideas because*

I get so excited about them, and to be connecting with women from all over the country who also bringing in these new ideas into practice. You know, I get more ideas about how to move forward, or research to back up the need for this because I think often that's the way people work, is they need to have proof. And we might know instinctively or intuitively the links between trauma, addictions, and mental health but without the research to back that up, it's often not as compelling. So I thank you for everyone, and thank you to the facilitator for this forum.

4.4 Discussion

People working in a range of roles in the substance field, and with a range of expertise on women-centred work were interested in participating in a virtual community on the topic. At the time in 2009, the use of email for recruitment was effective for reaching and engaging these multi-sectoral participants. The recruitment process was enabled by the provision of a list of email addresses of those involved in consultations on the *National Framework*. Now with further virtual engagement in social media sites such as LinkedIn, it is possible that even without such assistance from the Canadian Centre on Substance Abuse (CCSA), participants could be easily recruited to fora such as this community of inquiry. Furthermore there are now virtual sites such as CCSA's virtual SystemAction and Ontario's EENet which use a "network of networks" approach to attracting existing and new networks to link together so that knowledge exchange is widely promoted. These networks of networks encourage the use of their sites for recruitment to events, courses and other forms of knowledge exchange.

The virtual nature of the community was important in attracting people to attend, and in making possible participation in pan-Canadian dialogue of this nature. The use of virtual communities is no longer so novel, and thus may not play as large a factor in motivating people to participate in such fora in the future. However the virtual nature remains critical to enable access to pan-Canadian communities of inquiry on gender-based analysis, due to funding restrictions, time and travel barriers in a large country, and the lack of critical mass of experts on gender in any one region of the country.

The voluntary nature of the community – emphasized at the time of engagement and for each meeting - was important. Research ethics boards may want to consider how

the agreement to attend is in itself a form of consent, so as not to create formal barriers to participation in communities being studied; as formal consent at the time of engagement created barriers for half of the participants who originally indicated interest in participation. Participation fluctuated considerably across meetings as work commitments arose for the community participants. Participation ranged from eight to fifteen participants per meeting, with no one dropping out and yet no one attending all meetings. This suggests that the timeframe and level of time commitment chosen – that is, monthly meetings over 6 months of 75 minutes duration - was as realistic as possible. It is also possible that this length of the community (6 months) was not long enough to promote the kind of trust, community or engagement in dialogic deliberation that could even more fundamentally affect participants' action. The open ended (versus time-limited) community of practice which I currently facilitate on the issue of prevention of FASD is another format for promoting linkages, dialogue, sharing of evidence, gender-based analysis and action to improve the response to girls and women who use alcohol. The core elements of short and long term communities which support consciousness raising and collaborative action will be discussed in subsequent chapters.

Each of the topics discussed were rooted in complex discourses and (in)action in the substance use field - discourses and action which are "gender blind", or "exploit gender", "accommodate gender" or are "gender transformative" (Interagency Gender Working Group 2004; Rottach, Schuler & Hardee 2009). These terms were first conceived by the USA Interagency Gender Working Group to describe the continuum of ways in which gender can be incorporated in the design, implementation and evaluation of programming reaching women on health issues:

- The term **"gender blind"** refers to the absence of any proactive consideration of the larger gender environment and specific gender roles affecting program/policy beneficiaries.
- In contrast, **"gender aware"** programs/policies deliberately examine and address the anticipated gender-related outcomes during both design and implementation.
    - **Gender exploitative** approaches take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives.
    - **Gender accommodating** approaches acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them.
    - **Gender transformative** approaches actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender-equity objectives.

These terms were not fully known or explored within the virtual community but have since been identified by BCCEWH researchers as helpful to women's health advocates contemplating action on programming and policy, after applying gender-based analysis to describe inequities (Greaves, Pederson & Poole 2014). This is one aspect of the facilitation of learning I would change in future virtual community processes: to guide participants to rate existing interventions on this gender intervention continuum, and to actively try developing interventions which meet gender transformative criteria.

This gender intervention continuum might have been helpful in critical analysis of the *National Framework* overall, and in evoking talk of action. The participants were recruited from those involved in the development of the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada*. This framework broke ground in its national scope, its consultative process and its development of principles "to guide the collaborative efforts of individuals, governments, organizations and communities" (p. 12). Within the principles, problematic substance use was identified as a health issue, one shaped by social factors, and one which requires a continuum of evidence based approaches including health promotion, prevention, treatment, enforcement, and harm reduction approaches. The document mentioned women as a "population with distinct circumstances" in the following list: "First Nations, Inuit and Métis people, offenders, women, ethno-cultural groups and seniors, among others" (p 15). In the framework, however under Priority Area 3 (p. 20), where the needs of certain key populations were identified and prioritized, women did not appear. Pregnant women were seen as important to support in relation to preventing fetal alcohol spectrum disorder (FASD) and women's health advocates were able to affect the wording of the FASD section to make mention of providing "women-centred and culturally appropriate services" to women at risk of having a child affected (p. 17), but otherwise this section refers to individuals and families. Thus, while the FASD section brings a "gender accommodating" element to the document, the framework as a whole - whether covering treatment for pharmaceutical drug problems, workforce development, the needs of children and youth or any other aspect of substance use - was gender blind.

The topics addressed in the community spanned the key issues facing the substance use field related to a sex- and/or gender-based response to the needs of girls and women. The context of the substance use field was repeatedly raised and considered, including the way in which the field has been blind to women's needs, merely accommodated them, or fully addressed them. Thus in spite of the *Framework*'s blindness as to gender, the participants who came to the virtual community, and who had been involved in some aspect of its development were capable: of discussing gendered approaches to prevention, treatment and harm reduction; in situating these discussions within the competing paradigms in operation in the substance use field (as described in Chapter One); and in sharing the results of these discussions within their workplaces.

The community sessions included a mix of didactic material, directed discussion and open ended reflection. The sessions required more orchestration by me than anticipated. Multiple sources of evidence were presented to increase awareness of gendered inequities, to support active participation in synthesis, theorizing and reflexivity. The appreciative inquiry approach served well to create space for the acknowledgement of challenges faced when applying gender-based analysis, and at the same time how challenges had been successfully addressed. The dialogic nature of the community supported connected knowing, consensual validation, and arguably some evolution of identity as advocates on gender.

The next three chapters will look at these findings in the light of:

- how the components of feminist action research – such as inclusion, participation, individual and collective action/efficacy, social change, empowerment – are, or are not realised (Chapter 5).
- how current approaches to social learning (such as communities of practice) and constructivist learning (such as communities of inquiry) – specifically those with foundations in dialogic processes, conscientization and transformative learning - can support knowledge translation goals on complex health issues (Chapter 6).
- how virtual locations can facilitate the process of sharing knowledge across boundaries (geographic, sectoral, cultural), and the potential for scholars to act as brokers, facilitators and boundary spanners in such processes (Chapter 7).

Chapter 5 – Applying a feminist participatory action research lens

This chapter will examine the process and outcome of the virtual community through the lenses of feminist research praxis and pedagogy. Aspects of the virtual community will be considered in the light of these theoretical and pedagogical frameworks. The focus is to reflect upon what feminist participatory action research, consciousness raising and pedagogy have to contribute to the enactment of knowledge translation in virtual contexts, with diverse participants, on complex health issues where paradigmatic shifts in perspective are desired. This process of viewing the community findings through these lenses is designed to generate an answer to whether feminist participatory action research can be enacted in the online environment. In this chapter we see not only what feminist participatory action research practice contributes to online communities of inquiry but also how it may both be both constrained and evolved in this process.

5.1 Introduction

In 2012 a report was released entitled “Forsaken” (Oppal 2012) which chronicles how the Vancouver police forsook 67 women reported as missing between 1997 and 2002, largely because “this group of women shares the experience of one or more disadvantaging social and economic factors: violence, poverty, addiction, racism, mental health issues, intergenerational impact of residential schools and so on.” (p. 78). It was later established that these women were murdered by a serial killer. While the report focuses on the lack of police response to the missing and murdered women, Commissioner Oppal points out that “broader forces of marginalization and societal dismissal were also at work” (ibid.). In fact he describes the story of the missing and murdered women as a “complex, multilayered one consisting of individual histories, broader patterns of social disadvantage and social exclusion, and wholly inadequate policy responses” (p. 82). It is a similar long term dismissal of substance-using women and inadequate policy responses which underlay this study and motivated me to consider the need for the use of a dialogic space to allow for consideration of the influences on girls’ and women’s substance use and of more adequate responses. Given

this motivation, examining the results of this study through feminist lenses, particularly an action-oriented praxis frame, is essential to derive knowledge for shifting this long term dismissal into positive action and policy changes.

Campbell and Ettore, in *Gendering Addictions* (2011) ask "why have women drug users been marginalized so consistently in treatment and policy circles?" (p. 1). They document how difficult it has been "for feminists to carve out spaces in which to create, support and sustain gender aware, gender sensitive or gender responsive drug treatment in the latter part of the twentieth century". They note how in general "knowledge making practices in the drug research and treatment arena make it resistant to acknowledging the gendered, classed and racialized power differentials that structure the lives of drug using women" (p. 1). In contrast, the learning environment of the virtual community provided an opportunity to bring together service providers and others in a position to influence women's treatment, to acknowledge these realities and to create openings for dialogue and potentially new responses.

While gender has long-been recognized as a social determinant of health, it has largely been ignored in many health initiatives (Gelb, Pederson & Greaves 2011; Greaves, Pederson & Poole 2014). Recent writers on gender have articulated the need for more attention to its role in influencing the health of girls and women (See for example, Benoit & Shumka 2009; McGibbon 2012; Sen & Östlin 2010). Gender roles, norms and relations shape the lives of both women and men through the process of conforming to expected behaviours and characteristics, exposures to risk conditions, experiences of discrimination and access to health services (Johnson, J, Greaves & Repta 2007). Gendered relations and institutional arrangements often result in an unequal distribution of power and the expression of this inequity can take many forms, including lower income for women, poorer nutritional intake, less access to education for girls, lack of autonomy and decision-making power on their reproductive issues, and more exposure to violence and abuse (Iyer, Sen & Östlin 2008; Sen & Östlin 2007; World Health Organization 2008) and use of substances to cope. Working together in synergy, the multitude of effects that stem from gender inequity contribute to poorer health outcomes for women (Greaves, Pederson & Poole 2014; Pederson et al. 2010; Sen & Östlin 2010). Consequently, a response by the substance use field that explicitly

addresses these processes and results is one part of a broader effort necessary to improve women's health and status.

Further, gender interacts with all the other social determinants to produce different health experiences for individual women and men (Sen & Östlin 2010). Gender operates at every level of health, structurally and/or systemically, via outright discrimination or tacit biases affecting women in a range of social positions (ibid.). As a determinant of health, gender grounds the critical need for actions that specifically consider the needs and experiences of women; however the need for action is often overlooked (Greaves 2014; Keleher 2004) Indeed, the everyday use of gender as primary frame for organizing social relations (Ridgeway 2011) is perhaps what makes it so difficult to see and tackle.

This study's community of inquiry was designed to assist practitioners in focusing on gender in order to increase their awareness of the role of gender as a determinant of girls' and women's substance use, and to consider strategies for action. The virtual space created for this study was designed as a context for knowledge construction and consideration of action, by and for diverse people working on substance use issues in Canada. Campbell and Ettore have discussed how women with substance use problems were not seen as "epistemologically credible" (2011, p. 2). I saw the need to support and enhance their epistemological credibility, as well as that of practitioners who work with women with substance use problems. The virtual community was designed to support understanding of the operation of gender and other determinants of women's health, and to catalyse action towards improved treatment, prevention and harm reduction initiatives. The community was a conscious effort to enact and examine feminist participatory action research in the online environment.

This chapter considers the process and outcome of the virtual community of inquiry in the light of feminist community participatory action research principles and practices. As Reid and Frisby (2008) cautioned against, I was not hoping to tie the community practices to "an idealized set of FPAR dimensions that are impossible to achieve" (p. 96), but rather to consider the virtual community in the light of FPAR principles in order to illuminate the strengths and weaknesses of virtual communities as approaches to effective knowledge translation with social justice goals. As such I have

taken up Reid and Frisby's invitation "to critique, modify, connect, and extend" (ibid.) these important FPAR dimensions. I have analysed the enactment of the principles in four sections: (i) how/was *gender inequality* discussed, examined and synthesized? (discussed in the section entitled increasing consciousness) (ii) how/was *participation* enacted? (iii) how/were *inclusion* and diversity handled? and (iv) how/was *action* conceived and enacted by participants?

As described, evidence from a range of research, practice and policy sources was first introduced, to clearly illustrate the operation of gender in the substance use field. Unlike knowledge translation related to individual studies, in this virtual community a range of studies that have taken gender into account in practice and policy settings was introduced to illuminate sex/gender factors, influences and inequities related to women's substance use, and to surface approaches to addressing ignorance and inaction on these gendered issues and inequities. Then, participants were encouraged to link their experiences as researchers, educators, service providers and civil servants to the material presented. As Nutley et al. (2007, p. 262) indicate, such inclusive and pluralistic arrangements can lead to "enlarged, reshaped and sometimes shared understandings" rather than remaining focussed on the development of "instrumentalist policy choices".

Enlarging understanding was facilitated through the presentation of evidence followed by discussion of the material as a group, whereby questions and comments could be heard and relevant experiences connected to the material. A conscious deliberative process was facilitated. This approach prompted more than an exchange of information, and facilitated a sense of uncovering of knowledge together, of making visible the power structures and relations, and how they play a role in promoting and sustaining inequalities. Finally, an effort was made to introduce research and relevant practice/policy applications, to facilitate multidirectional learning and consideration of how to locally apply the learning to practice and policy by leaders, who may not have previously had the sense of themselves as involved in the production of knowledge.

At the end of the first meeting, with the following summary, I tried to name the process in which we had been engaged, both as a form of critical appraisal that is linked

positively to praxis, and one that can yield ideas for practical, doable improvements in local contexts:

> *I guess that's my hope for this community, is to really think through, you know, how can we do this kind of more thoughtful approach? And it doesn't even have to cost more money, you know. Many of the best things that, -- like, the big study we'll look at next time, that SAMHSA did on making the system integrated on violence, mental health, and substance use issues. They didn't actually do anything new as much as they reorganized the way they did, the way they were delivering care to women, to make it trauma-informed as well as have some trauma-specific aspects to it. And -- to me that's our real challenge, is taking each institution or whatever, kind of location you're at, whether you're working in government or -- or delivering service, to really think, you know, how do we -- how do we shift just, you know, a half-turn, even, to be able to do things differently that would make a very significant difference to women's access and women's recovery overall.*

5.2 Increasing Consciousness

5.2.1 Making gender visible

> *Feminist action researchers facilitate building knowledge to change the conditions of women's lives, both individually and collectively, while reconstructing conceptions of power so that power can be used in a responsible manner (Ristock & Pennell 1996, p. 148).*

Central to feminist action research is the identification of gendered processes, issues and inequities as a foundation for action. In this community the propositions underlying gender described by Bradley (2007) were explored and illuminated: that gender is a social construct, and at the same time a lived experience; that gender as a social construct is "politically deployed" (p. 4) and the political relations of gender, "disparities of power between men and women affect us all in every aspects of our lives" (p. 5). In many feminist texts the importance of breaking the silence about gender inequalities, or rendering the invisible visible is mentioned (hooks 1994). In several ways the naming of gender issues and resistance to inequality was evident in the community.

Naming of suppressed issues

The marginalization of the needs and realities of women substance users were consistently surfaced and described related to each of the meeting topics. The lack of

attention among providers and society in general to issues such as the interface of pregnancy and substance use, the need for child care, the inter connected experience of violence, and the differential and more serious impact of licit drugs on women's bodies were all identified. For example:

> *And I think her lead time was three months, and that was very important because, for some women it meant convincing their husbands to let them go; for some, it meant organizing child care; and one of the earlier comments from your women, for the members on the panel today, that I thought -- really struck a chord for me, was that many of our women are afraid to go to treatment because they have to put their children in care, and they're frightened, and they will resist treatment.*

> *And it's interesting that those two, benzodiazepines and tobacco, are ones that the substance use field in general haven't dealt that well with, and so we've always seen, in the substance use field, you know, that men are higher users than women, and that's been the main story. But, you know, they're really only the higher users of illicit drugs, right? And illicit drugs have been the big story.*

Naming of gender exploitation

In the virtual community meetings, consideration of how power operates to reinforce gender inequities was frequently made. It was noted that when gender *is* attended to by influential societal actors or institutions, it is often done so in a way that exploits, or merely accommodates gender differences, rather than leveraging transformation in power relations as has been described in various transnational reports and articles related to gender-based analysis (See Greaves, Pederson & Poole 2014; Greene 2012; Pederson et al. 2010; Women's Health Victoria 2012). One participant described an example of how gender is exploited in alcohol advertising and exacerbated by lack of attention to the serious sex-specific health impacts of alcohol use, on the part of people working on breast cancer.

> *I'm in the area of alcohol, as you know, and I think that young women are starting to exhibit more risky -- signs of risky drinking, I think they are coming up to the levels of the young men in some circumstances, probably on university campuses, and the alcohol manufacturers are trying to build their market in young women. And so I just was bringing to Nancy's attention earlier this week that Mike's Hard Lemonade has a brilliant [meant in a sarcastic way] marketing tactic: they now have Mike's Hard* Pink *Lemonade and they launched it last week in partnership with the Breast Cancer Foundation! [the Breast Cancer group accepted alcohol funding based on the ploy of alignment with their pink branding, instead of refusing based on alcohol's role in risk of breast cancer].*

This type of sharing and analysis might not have taken place in a context that does not involve people from multiple sectors in an extended dialogue. This participant was speaking as an alcohol policy expert, concerned with pricing and other alcohol policy that affects health on the population level. Her unit in government was interested in this as an example of how alcohol is marketed to girls, yet following her presence at the first session of the community where a sex/gender/diversity based analysis (SGBA) had been used and the sex and gendered health impacts of substance use was discussed, she was further sensitized to how cynically exploitative this practice by the manufacturer of alcohol coolers was, and to the expediency of the acceptance by the breast cancer group of this advertising. As such SGBA was enacted as "a process of integrating sex and gender considerations into health research, policy and practice" (Clow et al. 2009, p.19) and one that is iterative,

> *which means regularly reflecting on content and process and adjusting to address gaps, inconsistencies and oversights as well as to accommodate new knowledge or insights. Iteration can therefore redirect an analysis to include other or additional populations, to consider an issue from a novel perspective, or to tailor recommendations or interventions for specific policy and practice contexts (*ibid.*)*

This example of marketing of a pink cooler to girls and young women underlines why it is important to understand gender inequality and how gender inequality persists. Ridgeway discusses how status inequalities such as gender are rooted in shared cultural beliefs "about the respect, social esteem, and honor associated with types or categories of people compared with other types or categories of people" (Ridgeway 2011, p.11). In this case a sweet and pink alcoholic beverage is being marketed, designed to increase its appeal to girls and women, and deflecting attention to the more severe health risks associated with alcohol use by girls and women. Alcohol, tobacco and mood altering prescription products are often developed and marketed in ways that deliberately exploit gender stereotypes and reinforce them in the everyday experience of men and women.

Naming of willful ignorance

Invisibility, ignorance and resistance to considering gender differences and the need for gendered responses were identified at multiple levels:

At the level of service provision:

You know, I had an interesting conversation with one of our youth treatment providers and asked the question, for example, "Do you do gender-specific groups in youth treatment", because of course the dynamics of girls and guys in a group together . . ." I said, "you know one of the things certainly for women in adult treatment is that the women are taking care of the men in a group -- in group therapy, and not focused as much on their own issues and, does that -- do you notice that that applies the same in the youth treatment groups?" And it was, you know, again, I think, a lack of even kind of thinking about that, the youth lens is one thing, in youth treatment and adult treatment, is different, but looking at it again from a lens of young women in youth treatment, and what their needs are. I mean, again, I think that's just another whole sensitizing piece for our staff, is, you know, what could -- what could we be thinking about and doing different for young women in treatment and young men, in terms of how we structure programs?

At the level of provincial ministries:

Because if a centre is funded, let's say, by a provincial ministry, it takes someone at that ministry understanding the difference in gender. And if, for example, a province only has twelve youth treatment beds, they're probably going to decide to say six female and six male and -- just out of no thought, put it in one unit. I know certainly I was working on a proposal with the province of [names province] for a new youth treatment facility, gave them a bunch of my experience, gave them a bunch of data from our centres, and they came back with one sentence: "We can't do that. We only have twelve beds." So -- they didn't want to put the effort or didn't know how to put the effort into trying to make it gender-specific.

At the level of key national funders and partners, I shared the following:

I was reviewing some proposals for Health Canada a while ago, some of the ones that had been submitted on youth treatment, and it was so interesting because I consistently raised about how, none of them had taken gender into account (or not none of them, but most of them). And, you know, I felt from some of the other reviewers a real sense of scorn, "can't you get off this topic"? And finally at the end of the teleconference where we'd discussed the proposals, they said, "Thank you very much," to everyone and "thanks to Nancy for her opinions." It was so interesting, you know, because clearly they had 'facts' and I had 'opinions'. And I guess that's why I'm so keen on getting some of this [evidence about gender] on paper, so that people can see that, you know, because the resistance is so high, I think we really need to build the evidence as best we can.

The operation of 'willful ignorance', as described by Tuana (2006) is evident in these comments. Tuana describes how it is important to understand the practices that account for not knowing (p. 3). The naming of how available evidence (e.g. on prescribed medications as significant problematic drugs for women) is ignored and withheld can be a step in claiming this knowledge, sharing it in one's communities of

influence, and thereby beginning the process of disrupting the gender bias of currently operating frameworks for understanding substance use. The naming of licit drug prescribing practices has been recorded (Currie 2003, 2007), however the opportunity to situate gendered prescribing practices and related issues within a larger lack of attention to women's substance use and to discuss it in this context was unique. This type of discussion - where "ideological, political and social processes underlying and permeating systems of inequality are exposed" (Lykes & Coquillon 2007, p. 298) - is a key aspect of feminist action research.

However while such issues as the over-prescription of legal drugs to women, and the lack of attention to the health impacts of these legal drugs on women's health were raised, discussion on this particular topic did not extend to how drug companies as global capitalist forces would be resistant to change (Currie 2003; Rochon Ford & Saibil 2009). Nor in the discussion of this issue did participants engage in intersectional analysis: as to how these drugs differentially affect older women (Therapeutics Initiative 2004), young women with experience of trauma (Chaim & Henderson March 17, 2009), or Aboriginal women elders (Salmon A 2006). While sex-, gender- and diversity-based analysis was enacted in the presentations made to the community and in brief discussions, the length of the webmeetings and perhaps the level of awareness of the participants did not generate extended gender-based, integrative analysis (Bell, Morrow & Tastsoglou 1999) beyond the identification of invisibility of the evidence and concomitant inaction. This outcome of the discussion of licit substance use by women was an early signal that the virtual community needed leadership beyond what might be enacted in a typical participatory action research model.

Comments by participants on ignorance of and resistance to applying a gender lens in the substance use field illuminated how those who speak of gender issues themselves can be marginalized; how the concerns of advocates of gendered approaches are often interpreted and denigrated as 'personal' issues, which can lead to further silencing and persistence of gender-based inequities (Kirby, Greaves & Reid 2006). A notable example concerns the unsympathetic view of substance-using mothers and the extension of this view to those who advocated for more understanding of the potential of substance-using mothers. Regarding the author of a book on women and substance

use issues cited in our discourse analysis of Canadian print media and substance-using mothers (Greaves et al. 2002) the following was noted::

> *In several articles, Dr. Susan Boyd (1999) was interviewed about her book, Women and Illicit Drugs: Transcending the Myths, in which she challenged the automatic equating of substance-using women as poor mothers, contexualized women's use and challenged the lack of systemic support provided to substance-using mothers. In one article on her research, Boyd was labelled as part of the "cement of academic gender feminism," "naïve," "curiously indifferent" to the needs of children and a poor writer. In another article, she was asked if she was a mother (as if being a qualified researcher would not have been adequate). Further, a letter to the editor suggested she was "hoodwinked" by the 28 drug-addicted mothers she interviewed, when she represented them as having the potential to be good mothers."*

While the naming of the resistance to gendered approaches and those who advocate them might have fostered discouragement, in fact it did not. As described by Hemmings and others concerned with the linking of affect to knowledge generation (For example, Code 1991; Jaggar 2007b; Luhmann 2012) this aspect of the collective inquiry process - where the realities of how evidence about gender has been ignored and how feminists have taken action to make women's substance use visible - served to evoke empathy and respect for participants' work, and inspire action to change these conditions. The opportunity to name challenges and express some frustration about the inertia of the system's response, relate to what Hemmings describes as "affective solidarity" (2012, p. 148).

Discussion also took place on how power operates in a way that was linked to envisioning how we might work differently, giving the webmeetings a positive tone and change-orientation. For example I proffered an example of how we applied a gender analysis to the addictions system in the course of developing the national treatment strategy, which allowed us to identify how to mainstream gender within all levels of care, as well as how to provide some gender specific services (See Chapter 4 – pp. 89-90). This particular point about systemic analysis (and the difference between women being seen as a 'special population' versus using an axis of systemic gender-based analysis) was later mentioned in the post community focus group as important to one participant's learning and approach to future work in the field. In this way, the virtual community definitely served to make the contribution which Campbell and Ettorre see as important: "to cast doubt on normative beliefs and practices based on willful

ignorance, (2011, p. 7) to "identify how epistemologies of ignorance work" (ibid.) and to begin to effect change, or to "help shape effective 'cultures of action" (ibid.).

5.2.2 Building an epistemic community, to support consciousness raising

To achieve the goal of raising consciousness about the operation of gender in the substance use field, a space for collective examination of evidence was critically important. The virtual community provided the opportunity to consider multiple types of evidence, beyond the academic evidence only, and in particular academic studies taking a gender-blind approach, as are commonly published in the addictions field. Both creating the space and supporting the engagement with feminist, as well as mainstream evidence seemed important, and so I turned to feminist pedagogy for direction.

A number of conceptualizations of feminist pedagogy (in the non-virtual environment) have been articulated. Key articulations of feminist pedagogy were published in the early 1990s (Briskin 1990; hooks 1994; Shrewsbury 1993). A second wave of interest in feminist pedagogy (and its measurement) occurred in the early 2000s (Campbell, K 2002; Macdonald & Sanchez-Casal 2002; Moya & Hames-Garcia 2000; Stake & Hoffmann 2000; Webb, Walker & Bollis 2004). Campbell (2002) focused on the decentering of authority in feminist pedagogy; the relocating of it in the community of learners; and the role of the teacher in facilitating safe and equitable participation of learners. Stake and Hoffmann (Hoffmann & Stake 1998; Stake & Hoffmann 2000) synthesized previous work on the subject to identify four key elements of feminist pedagogy as including: (i) participatory learning, where multiple views and perspectives are investigated; (ii) validation of personal experience, where legitimacy of experience as a source of evidence and perspective is included; (iii) fostering of the development of political/social understanding and encouragement of activism and (iv) development of critical thinking and open mindedness, where evidence from multiple sources and perspectives is evaluated, tolerance for ambiguity is evident and ability to empathetically engage with diverse others is made possible. Sanchez-Casal and Macdonald (Sanchez-Casal & Macdonald 2002) explored in some depth the challenges associated with restructuring authority and legitimizing experience in feminist pedagogy, and proposed the pedagogical strategy of *communities of meaning* as ways to "manage the proliferation of experience-based knowledge claims and avoid the anti-

democratic tendency to see experiential claims to know (especially about oppression), as sacrosanct" (p. 2).

More recent writings on feminist pedagogy have not significantly advanced these core conceptualizations, or situated pedagogy in current feminist theoretical and epistemological discourses. Crabtree and colleagues (Crabtree, Sapp & Licona 2009) "looked back to look forward" to describe feminist pedagogy as "a particular philosophy and set of practices . . . that is informed by feminist theory and grounded in principles of feminism" (p. 1). They note how feminist pedagogy "acknowledges personal, communal and subjective ways of knowing" (p. 4) towards "promoting consciousness raising, personal growth, and social responsibility" (p. 6). Luhmann (2012) takes up how, if teaching in women's studies is to match "the liberatory and emancipatory goals of the field" as described by early feminist thinkers on pedagogy (p. 67), that the focus needs to move from teaching to learning, and to paying close attention to the complexities involved in learning. While feminist pedagogical practices have not greatly expanded, significant developments in feminist theory, epistemology and practice (such as feminist action research) have informed the present study and shed light on current enactment of feminist pedagogical practice.

Collective exploration of multiple sources of evidence

> *Knowledge then is a convention rooted in the practical judgements of a community of fallible inquirers who struggle to resolve theory-dependent problems under specific historical conditions (Hawkesworth 1989, p. 549)*

The first dimension of feminist pedagogy applied in this study is the decentering of research as the privileged form of evidence. In this case such decentering was accomplished through the experience of professionals working in policy and practice settings in the substance field, who are challenged to bring gender-based analysis and gendered treatment responses into practice. Closely connected to the valuing of multiple forms of evidence is the focus on engagement by the participants with these multiple forms evidence, and some decentering of teaching or leadership in favour of collective engagement and learning. Such engagement directly challenges the assumption that exposure to strong research evidence will be an adequate foundation for learning, and that research evidence singularly provides the necessary basis of strong public policy

and clinical practice. Instead "both feminist scholarship and PAR recognize that knowledge is created in the context of genuine human relationships and further that both knowledge and social action are created as the result of specific groups of people acting as subjects rather than objects of the inquiry process" (Maguire, Brydon-Miller & McIntyre 2004, p. xiv).

The potential for collective engagement in learning that might help virtual community participants to act has a basis in feminist epistemology: In order to shift the invisibility, marginalization and inaction on women's substance use, it is necessary to identify and change the "various influences of norms and conceptions of gender and gendered interests and experiences on the production of knowledge" (Anderson, E 1995). In her book *What Can She Know* feminist epistemologist Lorraine Code quotes Wittgenstein on intersubjectivity: "knowledge is in the end based on acknowledgement" (Code 1991, p.215). As she further argues in *Rhetorical Spaces* (Code 1995b, p. xi), spaces where acknowledgement is "readily achieved or where it is thwarted; where cognitive authority is readily granted or denied and silenced" matter, in the collective construction of knowledge and to collective analysis by participants (such as the ones in this study) who are situated in day-to-day practice and policy making. Code sees in these contexts or spaces, where "concrete moral and epistemic agents are engaged in deliberations that matter to them" (1995b, p. xi) and knowledge production is a communal endeavour, that acknowledgement of experience and other forms of knowledge is critical. In these contexts, cooperative and interdisciplinary feminist inquiry is visible when knowledge that is constructed piece by piece, with help from one another, to assist in determining what we know. This approach requires a commitment to dialogue, debate, queries and critiques, and to the avoidance of totalizing or reductive solutions.

In the early consciousness raising groups, feminists made sense of our experience through naming and challenging power relations. Building on this model the virtual community with knowledge translation goals became an inter-subjective space where diverse people could come together, to consider our relationships to each other and the similarities and differences among our experiences, and to validate and expand upon what we know. Such a community need not depend only on accounts of experience, but rather gives us the opportunity to reflect on our experiences and wider

sources of evidence, and interpret both to produce knowledge about how gender, class, race and other dimensions of marginalization and oppression were operating in the substance use field. Experience is thereby linked to other forms of evidence, to identifying what needs to be transformed and to larger theory. In a virtual community operating on feminist pedagogical foundations, the experiences, conceptualizations of experience and judgments about what should change are both varied and interconnected. The goal is not to reach consensus on what we know, but rather to connect and weigh our experiences, to see experience, practice, policy and academic evidence and other forms of knowledge as shifting and changing as we interact, and to link our experiences and other forms of evidence to theory about (often) hidden, gendered relations of power. In this way experience is not essentialized but collectively interpreted, to see difference and similarity and to become a source of contribution to transformative agendas. The virtual community became a collectivity in which we could be socially situated, and within which we could think - a community where feminist and other forms of knowledge are acknowledged, validated and questioned.

In such a consciousness raising space, academic evidence and the practice and policy-related experience of participants were not seen as dualistic, or as opposite ends of a continuum of evidence. As Anzaldua (1990) has noted when describing mestiza consciousness, an understanding of multiple often opposing ideas and knowledges was involved, and negotiating these knowledges requires more than assuming a counter stance against dualistic views or forms of knowledge within and between participants. The community becomes a place to think about race, class and gender, where women from various social locations who share the interest of opposing and transforming the systemic gender-blind domination of the substance use field can become a “community of resistance” (Mohanty 2003, p. 47). This aspect of the community will be discussed further later in this chapter in the section entitled “Inclusion”

In short, in the virtual community key aspects of feminist pedagogy were enacted: multiple views and perspectives were investigated; evidence from multiple sources and perspectives was evaluated; personal experience was legitimized as a source of evidence; political/social understanding was fostered; and critical thinking was practiced. In the next sections of this chapter the quality of participation, the nature

of inclusion and engagement with diverse others and the fostering of activism – other key principles of feminist pedagogy - are described in more detail.

5.3 Participation

> *I want to argue that the quests for knowledge can only transcend the ambiguities of reason, passion, objectivity and subjectivity if the quest is a collective one.*
> Mary O'Brien (1989, p. 249)

Participation is a core principle of feminist action research, both to redress the historical marginalization of women's voices and agency, and as a mechanism for facilitating empowerment (Reid 2004). I framed the methodological orientation to create space for consciousness raising, knowledge construction and consideration of action to transform gendered relations of invisibility and marginalization on the part of diverse participants working on substance use issues in Canada. One aspect was the creation of a participatory and equitable space for the inquiry process. This section considers how such participation was enacted.

Participation was fostered in a range of ways. At the simplest level it began with participants introducing themselves at the opening of each session. In doing so, they most often located themselves by their geographic location in Canada, their type of work (as service providers, educators, policy analysts, researchers, academics, system planners) and the populations with whom they worked (with young women, Aboriginal women, rural women). The awareness of each other was aided by the fact that participants could see the names of those attending on the right hand side of the screen, and see who was talking at any point [the image of the phone beside a participant's name shakes when they are speaking]. In each meeting, large group discussion of presented material took place. The time for discussion in each webmeeting was at least as long as the time of a presentation or didactic component, in some cases twice as long. This section of the session was modelled directly on a consciousness raising model, where participants are invited to share their experiences, and reflect on how their practice links to the evidence and application of evidence presented. As well as listening and discussing all the evidence presented, some community participants presented exemplary examples of their practice, which took gender into account. External

practitioners, educators and researchers working in contexts directly comparable to the participants' experience also came into the community meetings to make presentations on their work. Participants were offered the opportunity to pick the topics of importance for the community to discuss, and to suggest external presenters. As facilitator I modelled a reflective and appreciative approach and promoted dialogic strategies to build a community experience thereby encouraging participation was encouraged in a range of ways and levels.

5.3.1 Voicing experience

Feminism and action research have consistently valorised lived experience or local knowledge, and have acknowledged where women are situated and working as a starting point for developing a broader understanding of structures and their potential transformation (Merrill 2005, p. 46). Experience or local knowledge can be seen as situated, partial, specific and particular (Haraway 1991) and therefore collective engagement in the construction of knowledge is important. This transforms partial, situated knowledge into knowledge that has the potential to provide a holistic understanding. In this view no individual has a truer, or more comprehensive view of social reality, indeed one's location may "facilitate or block the achievement of certain insights" (Jaggar 2007a, p. 306). As such it is important to engage people in the process of knowledge generation and to see the relational nature of knowledge. Such engaged knowers are not generic or detached, and "subjectivity is an important and indispensible component of the process of gaining knowledge" (Tuana 2007).

Occasionally participants prefaced their remarks from a particular location – here as a mother and as a professor, recognizing the validity of these locations.

> *And, you know, I mean, there's other -- there's such great stories. I mean, I had my first twelve year old in co-ed treatment and then the second just about that long in gender-specific and just the entire differences of the way the kids were allowed to be kids, you know. And the girls actually, you know, having pajama parties where they're doing all their hair at ten o'clock at night, which never happened in the co-ed treatment centre. You know. They wouldn't allow themselves to be seen that way.*

> *I say this because I -- even in teaching sociology, I, you know, try to get students to think more critically about this issue [harm reduction approaches with*

pregnant women] and, you know, it's the one place where I get a lot of pushback from students, even around the question of alcohol and pregnancy.

Participants also frequently located themselves relative to the women they serve and stressed the importance of bringing the voices of women with substance problems into program design:

but initially they [an outreach program for pregnant women] thought that they would be directing them towards treatment programs . . . and they found out that a lot of the women with addictions problems actually didn't want to go to a formal treatment, that they needed more on-the-ground support, like some people have mentioned already. [another participant adds] And that's so fitting with, you know, harm reduction philosophy in terms of the people that are actually being harmed have a say and have a voice

They also saw the importance of inclusion of parents and other community members in action on substance use issues:

In Vancouver, you know, we've had a little bit of luck with that in two ways. And one is with a group of harm reduction advocates holding public dialogues on some of the issues, right? But one of the things that's really, I think, made those dialogues work well - and the rest of the people from BC, you can correct me on this - but one of the things I think has really helped is that some parents of kids who have drug problems have really stood with us on this one.

Their participation also involved linking up their experience and perceptions with those of others, and validating the work of others:

That's great. That is so interesting to hear, you know, just how much wholism you have been able to build in with all of those different topics and . . . to focus on the woman's health as well as her parenting, I think, is a really neat linkage there.

how do we bridge that gap between what we know and what the public know? . . . I'm curious about people's experience with that, about how they've been able to bridge that gap? And that's why I was so glad that you mentioned those principles in it, because to me those principles are really helpful and can be adapted for us all, that idea of flexible and acceptable, holistic, let's practice collaborative harm reduction. I mean, that's straightforward. I mean, for us to all think about, well, what -- what does that mean in our context? And, as you say, it doesn't have to be a full program, it can be, you know, done collaboratively with another service or as -- you know, we've talked about here, [names participant] talked about a women's centre sponsoring it

This type of listening, acknowledging, linking and validating is evident in what Keating describes as 'step one' of feminist consciousness raising contexts, where

women share “experiences related to a theme in a way that pays close attention to the contexts that and histories in which the experiences being articulated are being played out”(Keating 2005, p. 86). It illustrates how “serious” and “respectful” listening was taking place, which linked the personal with the academic (hooks 1994, pp. 150-151). It further illustrates the power of connection and validation in such dialogues. Such exchanges show that participants experienced empathy for others’ positions. Empathy has been identified by Patricia Hill Collins (2013) as an important skill in critical practice, where, as we develop critical consciousness of our own experience, the experience of others can be imagined. The quote above where feelings of enthusiasm and curiosity are expressed demonstrates the epistemic potential of sharing experience and expressing emotion. Feminists such as Alison Jaggar have described emotions as “ways in which we engage actively and even construct the world” (Jaggar 2007b, p. 382) and as such, how dispassionate inquiry is a myth.

In voicing their experience in working on substance use issues, participants tied together issues in reflective ways, making quite complex links. For example, the links between grief and loss, women’s substance use, pregnancy, and risk of having a child affected by fetal alcohol spectrum disorder were brought out.

> *And, Nancy, the big thing they’re also doing, too, is reducing that grief and loss for women. I do some training around non-death grief and loss for women, and the piece around that, . . . if you help reduce the impact of that grief and loss, a lot of times, women aren’t getting pregnant again so soon.*

The links between early attachment problems and functioning in adulthood, and the implications for support as women leave prison was mentioned.

> *I just wanted to add, I really appreciated the comments about attachment disorder with children but one of the things that we’re discovering with our moms is that they have their own attachment disorder issues. Pre-release from prison, we’re attempting to design a process where they can address that*

A further example of how participants tied together ideas is evident in this comment where several participant’s points, and the literature are brought together, and it is stressed how important and how rare it is to have the opportunity to examine issues and the applicability to one’s own values and work.

> *I wonder how much of that Deb speaks to -- and this is just some of the work that we’ve done on women-specific treatment, but is just -- like, what you just put up, Nancy, the -- Jean Kilbourne’s work there -- is that understanding*

amongst those who work in the system, for example, Denise, you gave the example of the -- Mike's Hard Lemonade, and people not seeing that there is something wrong with that, right? And I wonder how much do we have to -- and how do we inform the treatment providers, those who are in the system, to kind of examine -- you kind of have to examine your own life and your own beliefs, right? Of all of that, and that -- at least in our work with the women, that -- that seems to be kind of the foundational component. .

5.3.2 Building participatory space to support listening and response-able[8] knowing

Central to participation in this community was the opportunity to both speak of one's work on gender and substance use issues as well as have the opportunity to listen to, empathize with and learn from each other. One of the key evidence based treatment modalities in the substance use field is built on the idea of having people speak of the change they would like to make and to have this 'change talk' heard and reflected back to them in an empathetic way (Miller, WR & Rollnick 2002). The point is for a client with substance use problems to have one's internal ideas for change voiced so that they can hear them, have another hear them and together amplify the intention for action. There are parallels in the dialogic process of the virtual community, whereby the opportunity is made available to voice one's ideas for improvement in practice and policy, to have others' listen, and thereby have the intention for individual or coalitional action potentiated.

Feminists such as Susan Bickford who are interested in change on systemic and political levels have discussed the importance of communicative interaction, of speaking and listening together, as we work through the challenges of deciding upon action to be taken on complex issues (Bickford 1996). She stresses the importance of listening; sees that helping people see our points of view is workable only if we listen to each other; and notes how not-listening is a form of power. In the case of this community, the point of creating space to listen was not necessarily to strive for a consensus or collective action, but rather to learn about common interests and differences in our contexts and to be inspired to act in contextualized ways. In fact in many community based participatory processes, listening is seen as a core principle

[8] Response-able knowing is a term offered by feminist philosopher Lorraine Code in her 1995 book **Rhetorical Spaces** , where she discusses knowledge as a social construct produced and validated through critical dialogue

(Minkler & Hancock 2008) helping the participants to understand both sources of oppression and strengths and assets. Lewis (2014, p. 32) notes that in engaging in collective critical analysis, the aim is not only about interpretation but "about fostering the possibility of connection – moment-by-slippery-uncertain-moment connection".

Women's experience as a form of knowledge has been much discussed and debated in feminist circles[9]. Early feminist consciousness raising groups pioneered the practice of including gendered personal experience as important subjugated knowledge important in knowledge development processes, and of collective involvement in knowledge production relevant to women's experience and of action to address women's inequality. Early consciousness raising group practice involved listening to women's narratives, considering their particularities and contingencies, linking up this situated knowing, and using this synthesis to develop a broader understanding of larger structures and trends, and identifying how these can be transformed. The feminist consciousness raising method was radical both in bringing forth women's experience as a legitimate form of evidence, and in indentifying the importance of a collective process of linking of narratives to theorize and promote action.

As Angela Miles describes: "this collective process of self-reflection and self-affirmation stands at the core of integrative feminist practice" (Miles 1996, p. 4). However the importance of sharing of experience has sometimes been misconstrued as enabling a form of personal sharing or confessional. In this study, and as is more properly understood in feminist consciousness raising and pedagogical processes overall, the sharing of experience is achieved through a dialogical process to create what Harding called a "potent form of objectivity" (Harding 1987). In fact what is being created is room for reflection by participants on how gender bias and structural inequities operate in their various contexts, both for women with substance use problems and for themselves, for collective consideration of multiple intersecting realities that moves beyond narratives of any individual truths (Mohanty 2003). This form of reflexivity is aimed at participants' own practice and contexts for change.

[9] For example the book *Provoking Feminisms*, where leading feminist scholars such as Nancy Hartsock, Patricia Hill-Collins, Sandra Harding and Dorothy Smith revisit standpoint theory (debates republished from SIGNS: Journal of Women in Culture and Society).

In reflexive community-based processes it may become possible to "uncover new angles of vision, reveal invisible barriers of power or ethical concerns, and lead to greater understandings, fewer hierarchical relationships and more authentic research".(Hesse-Biber & Piatellli 2007, p. 496). Throughout the community, gender and women's health was considered as an axis of identity and inquiry, intersecting in complex ways with other determinants of women's health[10]. Such spaces may also make room for reflection by participants as themselves benefitting from social inequality (Mohanty 2003); and on the constantly shifting nature of identities and oppressions. The community space was designed to reveal the complexities of participants' experiences - their participation in, as well as resistance to, oppressive practices (Augusta-Scott 2007). Thus in virtual communities of inquiry that engage with women's health issues, as with women's studies classrooms, not only may awareness be raised, but agency, acts of resistance, and approaches to addressing social inequality may be considered and/or evoked.

Returning to the concept of sharing experience, listening, empathizing and validation, and the importance of not over-individualizing subjectivity in such processes, Hemmings' concept of "affective solidarity" is relevant: that draws on " . . . affects such as rage, frustration and the desire for connection – as necessary for a sustainable feminist politics of transformation" (2012, p. 148). Hemmings notes how feminists have been concerned with dialogue and connected knowing, and takes this further by noting how feeling for others in collectivities such as in this study supports how people can transform themselves and their world. In this view, participation includes affect and cannot be reduced to experience grounded in various social, political, cultural and economic inequalities. In Hemmings' view one must feel these inequalities, and/or feel undervalued as an impetus to change. Communities such the one in this study allows for understanding of the dissonance and the movement from individual experience to "collective feminist capacity" (2012, p. 150). She sees that "feminist epistemology has prioritised the ability to appreciate the other, to render them a subject rather than an object of inquiry, as central to an alternative, politicised epistemology" (2012, p. 151).

[10] Notably not in dichotomous relationship to men's health

A related thread I wove into the creation of participatory space for critical feminist inquiry was appreciative inquiry, with its assumption that "in every society organization or group, something works" (Reed 2007, p. 27). In this community, inspired by the work of feminist experts in appreciative inquiry, Jeanie Cockell and Joan McArthur-Blair (2012), critical and appreciative inquiry were linked to support participation in dialogue among participants working in diverse locations. Critical appreciative inquiry focuses on the best of what is, in order to build a positive future state, in this case, equity and social justice for women with substance use problems. Health researchers working from a broad community based participatory approach have also stressed these points about listening, sharing and working with positive examples. Minkler and Hancock (2008) discuss this in the context of a strengths-based approach to community asset identification and issues selection in community based research contexts. They advocate dialogical process involving listening for subjugated stories, recognizing and beginning with community assets (over problems) and using the power of dialogue to examine the sources and implications of participants' knowledge. Indeed health researchers using community based and feminist lens have consistently stressed the centrality of participation and collaboration (Wallerstein & Duran 2003)

A participatory learning environment grounded in feminist pedagogy therefore is more than a space for critique. It builds on the experiences of participants, encourages risk taking in expression of narratives and ideas, fostering connection and mutuality. In *Teaching to Transgress* bell hooks describes how engaging in critical reflection and in "the practice of feminism" (1994, p. 70) emerges from "efforts to make sense of the everyday life experiences" and from activism on personal and interpersonal levels. In this way, participation such as that enabled in this community can become the ground for liberatory feminist theory and practice. Lorraine Code might describe the virtual community as one that can create the space for "response-ability" (1995b, p. 13) or knowledge which is inclusive, situated, and has community and wider accountability. The community becomes a place for response-able listening, a participatory location where participants extend their understanding of both localized and systemic issues, through sharing and listening to the experiences of others, and sounding out ideas for action.

5.4 Inclusion

> *Therefore, what is at stake is creating a situation where learning involves something more than confronting difference as some form of otherness. Instead, learning should rather be understood as a process of unlearning what we always already know, a form of knowledge that in itself often is both partial and oppressive."* (Bondestam 2011, p. 149)

Inclusion is a central principle of collaborative inquiry and feminist participatory action research (Kirby, Greaves & Reid 2006; Reid 2004). In this case, the aim was for the community of inquiry to be inclusive of diverse groups working on the implementation of the *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada*, in all their diversity. In essence it was a test of whether inclusion in collective participatory inquiry by people working in different sectors and locations within a health-related field could catalyse shifts in consciousness and action towards equitable, gendered treatment approaches, in a way comparable to the shifts generated in feminist consciousness raising groups and feminist participatory action research.

5.4.1 Transdisciplinary and multisectoral inclusion

There are three aspects of inclusion and the practice of gender-based analysis and transdisciplinarity which are visible as one examines this community from the lens of inclusion. One is in the leveling of epistemic privilege, wherein researchers, practitioners and policy analysts are included, involved in learning together and in understanding each others' perspectives. Secondly in undertaking collective sex-gender- and diversity-based analyses there is as widening of the lens from women's substance use as 'the problem' to consideration of how racism, poverty, structural violence against women and other systemic forms of discrimination and oppression are at play, and concomitant identification of more comprehensive and nuanced responses. And finally there is a noticing of participants' own lack of inclusion, of their experiences of marginalization and stigmatization, and the ramifications for individual and collective resistance.

Those who participated in the community were diverse in location (province, community), age, race, and sector in which they worked (policy, service provision,

research, education). All who participated (as opposed to all who indicated interest) were women. As participants introduced themselves at the beginning of each meeting, it was largely by location and sector, that they self identified. The participation of people working in multiple sectors and the bringing of their research needs and experiences to the table was a central goal of the inquiry. Through such inclusion in a virtual space, it was hoped that the conditions could be achieved for bridging the perspectives that these different locations confer, and a leveling of the dynamics of power that each of these locations confer.

Often in feminist participatory action research, inclusion is seen to refer to inclusion of marginalized women directly, and the focus of participation is on the power relationships between two groups of participants (the academic researchers and the women participant researchers) and on their diversity (by race, income status and sometimes by other dimensions). The aim of such participation and inclusion is often to bring forth the subaltern voices of the women to make known their service needs. In this case, the focus of inclusion was on linking researchers with service providers, policy analysts and others working within the substance use field, and the focus of participation and inclusion was on bringing forth their agency to engage with evidence and construct paths of action related to the needs of women with substance use concerns. While service providers, policy analysts and other professionals are not commonly seen as marginalized; it can be argued that they are marginalized by gendered institutional relations and by their identification with the highly stigmatized women with whom they work. The intent of the virtual community of inquiry was not to replace or diminish the involvement of women with current substance use problems themselves, acting to resist stigmatization and improve their own lives. Instead the community was designed to have an additive effect, to promote and support the need for conscientization and empowerment of those in a position to act within women-serving health systems of care.

In the enactment of the community, I was concerned with the leveling of epistemic privilege among research, practice and policy, and in collective engagement with gender and diversity based analysis. I saw it as important to consider a space to discuss social disadvantage in a way that helped us see complexity of the issues facing substance using women and to consider how to advance a more just response. Like

Anderson and colleagues, I saw how often the experience of the disadvantaged other is objectified, and how we need "critical dialogues . . . that contribute to the disruption of essentialized and racialized thinking" (2009, p. 292). And like my colleagues in the other Centres of Excellence for Women's Health in Canada. I saw the need to move past using guides and checklists as a method to support gender and diversity based analysis, and instead to involve people in engaging in SGDBA as a process (Clow et al. 2009, p. 3).

In the presentations and discussions, the diversity of women's needs by location in the country, by Aboriginal status, by readiness for change, and by other social determinants of women's health was raised. The multiple and intersecting ways in which gender, income, violence and race frame the experience of women with substance use concerns were often identified. And the challenges of mothering for women with substance use problems were often mentioned in this SGDBA. The operation of stigma towards substance using mothers was often mentioned and the possibility of working in a supportive and holistic - versus demanding and proscriptive - way to address stigma and the complexity of issues facing mothers was discussed in more than one session.

> *And then the stigma, then that moral panic comes in, that there's something wrong with the woman morally, if she's using substances or alcohol, if she's drinking, when someone just mentioned, it may not actually be an addiction.*
>
> *that no one wants to talk about the third piece of that, that no one wants to talk about women of child-bearing years, mothers, in -- as the third stigma. (laughs)*
>
> *And it's really interesting to me because we've explicitly named that the interventions that they need to do fall into a framework of women-centred as opposed to fetus-centred, harm-reduction oriented as opposed to abstinence-oriented, and collaborative as opposed to proscriptive. Right? That that's the frame we want to engage people on. . . So how do we break it down into a place where you are supporting her, wherever she's ready," as [names participant] said initially, "like, starting where she's at as opposed to, you know, Step 10*

Participants spoke of how difficult it has been to move the focus in the field, from narrow approaches that focus on one type of substance use (addiction) or that in any way focus on inequities.

> *think that frame, that you talked about earlier too [names participant], about substance use, problem substance use, and addiction is a helpful frame, too, for people to get it, that not all substance use is addiction and requiring abstinence, by any means. That there's a continuum. And I often use that same continuum*

[names another participant], around mental health and mental illness, too, talking about mental health, mental ill health, right, and then mental illness, right? . . . And just thinking about those continuua.

I don't think people are on the same page at all, and maybe that's an area, when we are speaking about girls and women, I mean, it's so clear, those inequities and so forth, and how that all fits together. And that's a much -- I think more accurate understanding.

One participant offered a description of their narrative approach to offering gender specific services for mothers in a way that honoured women's Aboriginal status and addressed related inequities

So we provide counseling support, advocacy for predominantly First Nations women who are living in the community here and, in terms of integrating women's role as mothers into the services that we do, for myself I work a lot from a narrative therapy perspective, which tries to not only uncover the -- the -- some of the messages that society has about women and integrating oppression and how -- and trying to deconstruct some of these ideas that we have, but also to build on people's strengths and some of their commitment and values and beliefs.

There was considerable discussion about the challenges related to the community participants' own voices being heard on the topic of gender and other determinants of girls' and women's health. There was recognition of this as oppositional knowledge that should instead be integral to the discourse and action in the field, not oppositional.

I'll give you a piece of data that is quite amazing and I'll tell you what happened with it. And this story will sort of elaborate how big the problem is in policy. But we have one of our treatment centres that was able to retain a hundred per cent of the kids who started for two years. So not one kid left treatment, in two years. Gender-specific. When I was presenting to the province of Saskatchewan, the proposal for the new centre they were going to open, I used that data to say, "Here's some of what gender [specific programming does re retention] ". And the person who received it said, "That statistic is impossible. They must only take the easy kids.

Engaging with others in the substance use field afforded the opportunity for participants to see more about our own context and positioning and to pose and discuss questions and doubts.

And I wonder how much do we have to -- and how do we inform the treatment providers, those who are in the system, to kind of examine -- you kind of have to

examine your own life and your own beliefs, right? Of all of that, and that -- at least in our work with the women, that -- that seems to be kind of the foundational component. And you gave those examples as well, Deb, just with your group, you know, of it 'not being normal'.

In some ways, I feel like that is a lot of this work, is to have the kind of, you know, people who are willing to walk that walk with others, of this -- not being afraid in that moment that, when you're being kind of questioned about your credibility or your, you know, facts or whatever, just really invite people to examine their assumptions rather than, you know, rather than losing it in that moment. And -- and it just strikes me that that is a lot of the work we have before us, is to do that same kind of thing that you weathered, you know, as people had to -- had all their reasons why -- why we can't or why we don't want to change. It sounds so much to me like that moment of motivational interviewing.

we do a round table of issues and then out of that we may identify a particular issue that requires an action, and it might be a conference, it might be an abstract, it might be a million things, right, but it really takes a regular meeting of like-minded folks. We're all doing their thing locally but if you actually get together regularly and establish relationships, it becomes a great brainstorming capacity. You can't predict where it'll take you, but without it we remain pretty isolated. It's sort of like creating a social movement, very, very early days of that process. But I think relying on like-minded people but working in relatively, in effect isolated, because on any issue that's small – I mean it's large but it's perceived to be small.

In these discussions, it can be seen how those interested in participating in the community were crossing a border in their willingness to come to the community to discuss gender and substance use. Ackerley (2007) speaks of the importance of engagement with those at the margins of the feminist movement, and that in such arenas participants can gain experience in articulating the assumptions of the feminist consensus and defending it against competing alternatives (p. 56). This community was designed to involve, and make welcome, people who were not necessarily feminists, who were indeed more at the margins of feminism, yet interested in learning about gender and substance use, in gender-based analysis and consideration of modifications to prevention/treatment/harm reduction approaches that account for gender. An articulation of a general feminist stance against alternatives was not a goal, rather the goal was to create a space for the articulation of participants' efforts to respond to women's needs, in relation to wider evidence on gender-based approaches. And for this to be seen as legitimate scholarly practice.

5.4.2 Building dialogic space for making difference and border work possible

The virtual community supported the inclusion of a plurality of voices, for dialogue across difference, for teaching and learning sex/gender/diversity-based analysis and for "border" work (Brabeck 2004; Hill Collins 2013; Kim, HS 2007).

Dialogue across difference

Merrill (2005) might see this community of inquiry with diversity of participation (across research/practice/policy sectors, north/south distance, rural and remote/urban location, Aboriginal/non Aboriginal status) as an enactment of dialogical feminism whereby diverse others' experience can be listened to and valued. She cites the work of Puigvert to argue that a plurality of voices can be engaged in egalitarian dialogue; that the voices within such a dialogue can be valued according to the argument given, not the social position of the person speaking; and that such inclusive and egalitarian participation in dialogue is a key element in transformation (p. 45).

The possibility of inclusion and communication across difference has been discussed by many feminist theorists. Iris Marion Young (2002) contributed by pointing to the importance of not idealizing the dialogic process. She questioned the concepts of identification across difference, symmetry and reversibility (reversing positions), and instead invited consideration of "asymmetrical reciprocity" (Young 1997b, p. 39), and listening, respect and collective questioning as more realizable. From a stance of respect, "each party must recognize that others have irreducible points of view and active interests that respectful interaction must consider" (pp. 49-50). She goes on to speak for considering difference as a resource (Young 1997a, p. 67) and how confrontation with differing perspectives and cultural meanings teaches the partiality of one's own, knowledge. The opportunity to listen to, and question, differently situated knowledge (p. 69) adds to the social knowledge of all participants, giving all a wider picture of the social processes in which their own partial experience is embedded, and of the collective nature of solutions to problems.

Much dialogue, debate, and theorizing has taken place amongst feminists about important categories of difference when looking at gender as a category of oppression. Patricia Hill Collins (2008) has offered that indeed <u>all</u> women and subgroups of women

have partial situated knowledge, and that in dialogic processes such as this community of inquiry, it is possible "to consider other groups' standpoints without relinquishing the uniqueness of its own standpoints or suppressing other groups' partial perspectives" (p. 256). Feminist participatory action research processes do assume multiplicity and hybridity among participants and how this multiplicity and hybridity is constantly shifting. As Torre and Alaya identify:

> *When fully engaged, this multiplicity can ignite creative and rigorous questions and methodologies, highly nuanced analyses, and complex forms of action.* (Torre & Ayala 2009, p. 389)

Working the Hyphen and Getting Lost

A number of reflexive research approaches advocated by feminists are helpful in understanding the potential of virtual communities as locations for learning, connecting and taking away ideas for practice change. One is a particular approach to reflexivity which Michelle Fine discussed as "working the hyphen" (Fine 1994). Hyphen-spaces (e.g. insider-outsider) in research relationships become places of possibility where as researchers we can see how we influence and are influenced by research participants, and how we learn and are changed in particular ways as we account for ourselves and our actions, within community-based research processes. In a community with participants/co-researchers from different sectors, the potential for 'working the hyphen' is increased (between researcher-practitioner, practitioner-policy analyst, policy analyst-researcher, presenter-listener and so on). However inclusion does not mean that expression, listening, interpretation, synthesis and negotiation automatically take place across differences and commonalities. Brabeck speaks about the achievement of this through privileging the collective voice and analysis, not the individual, and through facilitating a "centerless dialogue" (p. 52) where the power dynamics are fluid. Cunliffe and Karunanayake (2013) advocate the use of the notion of hyphen-spaces: seeing this as a concept that offers a way of recognizing the complexity of research relationships, making choices about how to position ourselves and work within them, and understanding the implications for research identities and practice. They see that the intricacy and impact of these relationships are rarely captured in research accounts. However in this community, with its multidirectional exchange process among researchers, service providers, policy analysts, educators and various other differently located participants, it is possible to hear in the quotes how participants experienced

differences and commonalities, and understood themselves as occupying more than one position or location. From a feminist participatory action research framework, they not only offer ideas from their experience but actively generate knowledge and strategies for action in the dialogue with others.

It is important to consider as Patti Lather mentions in the preface of her book *Getting Lost* what are "the inclusions and exclusions at work" (2007, p. x) in a virtual community where collective knowledge generation and synthesis processes are taking place among diverse people across distance. Lather addresses the challenges on the level of methods. She questions what sort of feminist inquiry is currently possible given the limits of postmodernist methods on the one hand, and the oppressiveness of an audit culture which privileges positivist methods on the other. She encourages feminists to continue to interrogate our methods and practices, to consider how/if we can represent others in non-colonizing ways, and can engage with and negotiate complexity. The concept of 'getting lost' encourages us to forgo certitude in representing or speaking for others, the need to find a one 'best way' approach (p. 4), and discrete and linear methods; and instead engage with uncertainty, not knowing, complexity and difference, as useful ground for moving forward. In essence that is what a virtual community with knowledge exchange goals such as this, offers: to learn, discuss and engage with approaches to addiction practice and policy, and ways to integrate of sex, gender and diversity that does not necessarily leave the participant with a well defined path for action. Instead participants have had the opportunity to become comfortable with open ended discussion of issues and action within a dialogic space. As Patti Lather identifies: "This is a shift in practices of knowing from a science not only to grasp (understand) but also to engage" (Lather 2010, p. 87).

Border work

The participants crossed various borders to come into community: for example a *context* border to work in the virtual context (unknown to most), a *difference* border to share, listen and discuss issues with unknown people from a wide range of locations and a *content* border to become more aware of gender as it operates in the substance use field. Hudson (2012, p. 174) speaks of borders as not only crossed but also occupied. In this case I was creating a space for occupying and working across borders of sector,

discipline, geography, and of ignorance of the operation of sex, gender and diversity within the substance use field.

Moya (2006) has articulated how the inclusion of participants with multiple identities can be considered important epistemic resources, in part because people with different identities are likely to ask different questions, and bring in different perspectives. In situations where mutual respect and intellectual cooperation are the operating practices, the existence of such divergent identities might lead to a creative solution or advancement in knowledge (2006, p. 103). There was recognition of "how we cannot answer questions by ourselves, from one vantage point, or from within one category" (Hill Collins 2013, p.108). The inclusion - instead of 'othering' of participants occupying different locations (Sandoval 2002, p. 22) - gives recognition to these different locations, and support to the levelling of power. The diversity of perspectives and the design of the inquiry process functioned to expand and alter the dialogue, to foster transformation and action.

This was border work in that it increased understanding of how the substance use field has resisted acknowledging the gendered, racialized and otherwise contextualized power relations inherent in substance use discourses such as 'disease' oriented, or 'brain disorder'. It made visible how some drugs become 'outsider drugs', that is, for example how the field has resisted knowing about prescription drug problems as a gendered practice. Further it allowed participants to discuss and see "the multiple, overlapping, intersecting systems or relations that are historically constructed and recreated through everyday practices and interactions" (Mohanty 2003, p. 104), such as gender-blind programming.

This was border work also in the sense that participants had the opportunity to become more aware of the complex, gendered and racialized relations of power in which we are embedded. Forging a dialogue about our positionality was not designed to identify differences, but to help us see the potential for action – individual and/or collective. In this, there is a parallel to our goal of understanding women's substance use, not as different from that of men, but as the sexed, gendered and otherwise contextualised phenomenon it is. The community was designed to create the border space for developing what Mohanty (2003) has called 'oppositional consciousness': a

space for critiquing the prevailing knowledge and discourse in the field and our relationship to it. The space to speak of our understandings and actions, and reinterpret this work together in a collective context, helps to transform our experience, and supports identification with each others' oppositional struggles. Such "discursive repositioning" (Berryman, SooHoo & Nevin 2013) is a key theme of culturally responsive methodologies.

In this virtual community, women presented their differences: in roles (service providers, researchers, policy analysts, educators); as located in different parts of the country; as having worked a short or long time in the substance use field; and as Aboriginal or non-Aboriginal. In the discussions, there was acknowledgement of the enactment of these various and multiple locations and perspectives, no attempt to homogenize them, but rather to validate them and create the space to see "points of connection" (Hill Collins 2008). In Hill Collins view, "common challenges can foster similar angles of vision, leading to group knowledge or standpoint, that in turn can influence a group's action" (Hill Collins 1998, p. 201). In sharing and collectively examining their individual praxes, the goal as a pedagogical strategy was to make visible the operation of gender oppression in the field as well as actions to resist and change these conditions. In such participatory and inclusive enterprises, Brabeck argues that the there is some "reappropriation of collective voice and the rejection of definitions imposed by others in positions of power" (2004, p. 46). A deeper process is made possible, whereby structural roots of problems and possible avenues of change are discussed, not only participant experience and/or evidence from academic research. This understanding of border work, which has been visited and revisited in feminist theory and practice, and which supports voice, reflexive collaboration and empowerment, comprises a significant contribution to the practice of knowledge translation within virtual communities of inquiry.

5.5 Action

5.5.1 From knowledge seeking to strategizing, within and beyond the virtual community

So far, dialogue – critical feminist, participatory and inclusive - as a core constructive force has been discussed. In this section, the extent to which participation in the virtual community of inquiry fostered action for social change - a core element in consciousness raising groups and in feminist action research - is explored. For experts in action research, the action or social change element is based in addressing immediate needs, linking them to broader systemic issues; raising awareness of how social systems support and resist change; involving diverse people in partnering for action; elevating expectations, and supporting positive innovations (Bradbury et al. 2008, p. 90). Feminist action researchers have defined action as a multifaceted and dynamic process "that can range from speaking to validate oneself and one's experiences in the world to the process of doing something such as taking a deliberate step towards changing one's circumstances" (Reid, Tom & Frisby 2006, p. 317). Feminist theorist Bunch discusses second wave feminist theorizing and action. She describes this as a deliberative and iterative four-part process involving: description (describing what exists), analysis (analysing why it exists, its origins and reasons for perpetuation), vision (determining what should exist) and strategy (hypothesizing how to change what it to what should be (Bunch 1987, pp. 244-245). This conceptualization affords consideration of action with a critical feminist lens within and beyond the virtual community. It also makes possible the linking of feminist action research and consciousness raising processes with knowledge translation on contested women's health issues. The Bunch framework is used to thematically group the statements about various levels and timing of action engaged in by study participants.

Knowledge seeking, describing what exists, sharing learning

Volunteering to participate in the community was in itself a form of action, even a courageous one, given the marginalization of women's substance use issues in the field. Participants often mentioned their keen interest in seeking knowledge on the topic, their appreciation for the space where collective discussion could take place, and

their commitment to sharing the learning so that there would be a critical mass of colleagues interested in systemic and contexualized change.

> *When we, as we were having the meeting and then we went back to our team meeting for Women Services, I shared with that team that what I learned each week, and as a result of that we were able to continue to work together to try to get more people involved in Women's Services. . . . actually it's really nice to be involved in this today because it gets me thinking that I really need to strive to bring the information forward to others in the agency, and particularly the structural changes so that we can continue to do the specific work that needs to be done for each population for women and girls.*

For several community members, action consisted of sharing learning about 'what exists', with their workplaces, students and networks. Reid and others have considered how sharing or articulation of what was discussed in a community such as this can be considered action, when action is re-conceptualized for example as a collective process where participants can articulate the goals of their research and evaluate their work (Reid et. al. 2006, p. 327-8).

> *I've gone back there [to the web workspace] and actually have found it a really useful tool to pull off and circulate to colleagues, because there'll be bits and pieces of course that have, you know, less or more relevance directly to me and my work, but because of the network that we have I'm, you know, able to direct some of this new and emerging pieces to folks that are directly working in the field, and so I've found it just phenomenal as an opportunity for that*

In one case, two vCoP participants mentioned co-presenting (post-community) on the topic of the relationship between FASD prevention and larger alcohol policy. They identified how they saw this sharing of such important linkages as a form of action, even if the advocated changes within alcohol policies to integrate an understanding of gendered influences on women's drinking had not been achieved.

> *So we're mostly, at this point I have only raised the questions at various points as we haven't actually been able to shift anything yet, but you know I think even raising the question is a form of action in lots of ways.*

Analyzing current praxis and envisioning what should exist

There was opportunity to review evidence on a topic, to discuss it, to ask questions and thereby come to better describe what exists, why it exists and what might need changing. In this way, analysis of current research practice and policy, beyond describing or sharing experience was achieved.

-- we really feel that, the same as the women who come to the Enhanced Services for Women program, is that a lot of times what we [as researchers, service providers, health system planners and policy analysts] need to do is come in like we are this morning and just talk about it. You know, that [names participant] had a chance to say, "You know, I don't get the definition of harm reduction," you know, and other people can throw out their ideas and . . . , that's how we learn as well as how our clients learn, is kind of coming together and saying, you know, "So what are you doing here and how do you see this?" Because then it helps me see what I might do in relation to it all.

This type of opportunity to ask about how others have implemented gender specific practice proved important as a foundation for collective discussion and analysis.

how do we bridge that gap between what we know and what the public knows and, you know, sort of those lovely sound-bites that -- that kind of thing. I'm curious about people's experience with that, about how they've been able to bridge that gap.

Participants identified how important it was to listen to others' analyses about addiction, to prompt their thinking about how to apply such thinking to local structural changes in the system of care.

Well I was just listening quite avidly to that bit of discussion because I, my unit, the addiction prevention unit has been moved over to the public health portfolio, so it's been a really interesting process today around how addiction is understood within the Public Health environment and particularly around alcohol and there's just the work we're doing around developing an Alberta alcohol strategy, . . .

There were numerous examples such as the one above, which illustrate how the community involvement assisted participants in interpreting material and to think through the implications for action, for determining what should exist.

Another thing I'll draw to your attention is, in the newspaper this week, I saw information about a group that is calling on the government for a new cardiovascular disease strategy and there's no mention of alcohol as one of the risk factors. That's a major gap. So that's all I'll say for now and I'm hoping that we're going to be able to have conversations around prevention initiatives.

In the discussion of harm reduction I raised this point about gendered use of prescription drugs and about how prescription drug use, and influences on prescription drug use should be included when capturing and analysing prevalence of alcohol, tobacco and other drug use. As such this is another example of envisioning what should exist.

> *women are prescribed more psychotropic medications in every category, including painkillers, than men. Right? And I just feel like it's a whole area of harm reduction that we haven't, you know, gotten on yet. And was really trying to encourage the Canadian Addiction Survey folks to include, you know, more on prescription drug use when we're doing surveys about addictions.*

Participants raised the potential for all programs to undertake such analysis and envision achievable opportunities for change. In this case it was noted that action on gender does not need to be large and costly, but could involve delivering programming with the same staffing, in the same context (groupwork), but with the change that those groups would be gender-specific and the content altered to address gendered realities.

> *if programs were able to kind of see it that way, that we're not asking you to completely revolutionize everything, to be totally different, but that more that you're creating the space for, you know, the processing of it to be different, and not to have to worry, as [names participant] said, 'taking care' of the other gender or being triggered by the other gender, or whatever, that -- that might make it more possible for programs to see -- you know, to think about doing gender-specific work.*

Synthesizing, hypothesizing, strategizing

Campbell and Ettore (2011) have identified that knowing what women need is difficult to discern given how multiple levels of ignorance work along gendered, sexualized, classed and racialized lines. Participants shared this view: The participant making the observation below sees how it is important for gender specific substance use treatment services to work differently in a careful interlaced way with other systems, to reduce barriers and burdens experienced by women with substance use concerns, and to listen for what women are indicating they need. This is an indication of deeper analysis and synthesis beyond making services gender sensitive or gender specific.

> *I was going to start off by saying, you know, if you build it, it's not necessarily true that they'll come, speaking of women and women-specific services. Because one of the things that certainly is very evident here in [names province] is issues -- so many other barriers, you know, and, you know, women are juggling child care needs, and having to see a probation officer, an income assistance officer, and the list goes on and on, and oftentimes substance use – substance use is, you know, the way to deal with all of those other things and it's the last on the list in terms of priority. So, I think, part of what we need to do, if we're looking at specific treatment, is to assist in eliminating some of those other barriers and that takes a lot of thought and, you know, mindful planning and resources as well. So we've been -- I've been doing a little bit of writing on a case-management kind of model to women's addiction services here and see where that takes us.*

Another participant working with Aboriginal women spoke of how the discussions in the community influenced her to see the women she worked with in new ways, in this case not only from a justice and disability lens, but also as women with trauma histories and needs for routine physical health information and guidance. This shift in perspective to apply a women's health lens to benefit this population of women in this setting, prompted her to act to change their prison programming to include support on women's health issues, delivered in a trauma-informed way.

> *We are working with a group of Aboriginal female inmates, all of whom are affected with FASD. So we're working with a very special group of women, and as I mentioned earlier all of our ladies have addiction issues that are lifelong and brought them to Corrections. One of the things that changed my perspective was just maybe really – you fine-tuned my hearing, you made me pay attention, you made me listen to something that I hadn't been paying attention to.*

Another participant spoke of how the community helped her to think about the complex linkages among gender, ethnicity, homelessness and HIV. It prompted her to think about how to conceptualize the multiple, intersecting relationships among these issues and to ask the community about how one goes about describing these relationships and writing them into policy documents.

> *Well yes, well interestingly, we have been working on this policy document on and off for several years, and for very good reasons got sort of on the shelf and is now back. We have not in fact checked up gender as a theme through this and we're just in our sort of towards the end of our editing process and I will go back to my colleagues and see how we can address that. What I'm still finding my way on, in terms of policy documents and this particular one, is do you do it in a kind of stepwise fashion; you get the big document in the general direction going and then subsequently take out, so to speak, the special issues, which there are many; homelessness, gender, ethnicity, First Nations experiences, and of course that order is not priorized, it's as it occurred to me, so I don't know the answer to that.*

A significant link was made by a government analyst between pregnant women's alcohol use/prevention of FASD and the larger alcohol policy strategies on which she was working. This particular insight led to her proposing and negotiating a number of conference presentations post community with leading national organizations in a position to influence action on practice and policy

> *[participant] and I have been doing a fair bit of work around trying to think about how you fit the issue of prevention of FASD [as a women's health issue] into larger alcohol policy strategies . . . and so far largely have done things like*

> *spoken to the issue at CCSA's [Canadian Centre on Substance Abuse] conference in Halifax last year, and we are about to again reinsert that in a discussion at the Canadian Public Health Association conference in June in Toronto.*

It was interesting that the following participant [working in an Aboriginal community context] commented on the importance of having help such as in the vCoP, to consider the translation to practice on the smaller localized level. She saw that often there are broad substance use prevention policies (and presumably Aboriginal governance and reconciliation policy strategies) being enacted, without assistance for analysing and strategizing as to how such system level policy can be translated into local culturally safe and gender transformative practice.

> *I mean it's funny how I find in the work you end up sort of working on a variety of different levels and having you [knowledge translation expert] come to try to work at that level is fantastic for us because in our prevention work that we're doing, we have plenty of opportunities to take action and to implement this work that's sort of at a higher policy systems level, we don't always get those opportunities, so building on the smaller things but yet the big things that we're doing.*

In summary, the vCoP participants mentioned action both enacted and envisioned towards localized and broad systemic changes. Within the community, action took the form of sharing learning, linking and analysing evidence and experience, and collective synthesizing and envisioning change. This learning and theorizing promoted both localized and contextualized action well beyond the community. Given the distributed nature of the vCoP participants, unlike comparable face-to-face projects such as consciousness raising groups and feminist community-based action research, the action taken beyond the vCoP meetings did not involve the community members as a group. However participants mentioned how they shared learnings with their local colleagues, and how they saw the importance of involving others in coalitional action.

5.5.2 Discursive space involving engaged scholars in action

> *. . . the intellectual project of understanding the world and the political project of changing it* Nancy Fraser (2004)

Engaged scholarship

Structural gender inequality exists; violence against women and girls is prevalent; other forms of injustice interact with gender as determinants of girls' and women's health; substance use is often a response to the experience of violence and trauma as well as to other forms of cumulative sexist practices; women with addictions and those who advocate for them are marginalized in mainstream addiction discourses; and empowering, gender informed services and responses in the substance use field are critically needed. How might these inequities and entrenched patterns be shifted? The community was a space for making visible and for naming these realities, using critical reflection as a ground for generating new knowledge and ideas for action. the community was also designed to be a space where the activism-scholarship dichotomy was bridged (Sudbury & Okazawa-Rey 2009): a space where knowledge translation on women's health, sex/gender diversity based analysis, feminist participatory action research, and the steps of feminist conscious raising groups (voicing, linking, theorizing and acting) were all taking place.

In a space where various forms of evidence are being shared, stories of experience become resources not only for reordering experience (Stone-Mediatore 2000, p. 123), but for rethinking action. In this community, participants were distributed and as such, while coalitional action might have been an outcome identified and taken up, it was not. Yet participants were translating what they were hearing, learning, collectively analysing and synthesizing into local action.

An important element to feminist participatory action research was taking place in the form of bridging one's own work with others', as we co-located the current knowledge and experience in a virtual space for cross-cultural, cross-border processes. The participation in bridging is an important form of action in itself: as Anzaldua and Keating have famously said, "a bridge . . . . is not just about one set of people crossing to the other side; it's about those on the other side crossing to this side" (2002, p. 4). It is work to engage across discipline, sector, distance, commitment to activism and so on.

The community was a space where participants were/became engaged scholars (Van De Ven 2007) buoyed by what Mohanty has termed "a community of resistance"

(2003, p. 47). For the co-research process itself became a place where participants became more aware of oppressive processes at play in their daily work, in the daily work of others working on some facet of gender and substance use and as described in other settings in the literature discussed. Through the awareness gleaned, and through participation in this co-inquiry process, openings were identified where change could be made or pressure might be applied to influence systems of marginalization and oppression. As such the community of learners, which is examining evidence in many forms becomes a location for the enactment of engaged scholarship that has both a respected and liberatory tone. (Torrens & Riley 2009; Whelan & Lawthom 2009).

The naming of what bell hooks calls "interlocking systems of domination" (hooks March 1, 2014) is an important part of engaged scholarship, which disrupts dualistic thinking and prompts more complex forms of resistance and agency. The placing of oneself in a location for collective examination of systems of domination, where multiple forms of interlocking oppressions – racism, capitalism, patriarchy – are discussed, and where there is the potential to be called on being oppressive onself, is a serious and courageous act of accountability which participants took. bell hooks speaks of feminism as

> *"the one radical movement for social justice – that when a major critique was brought to bear upon it – i.e. the racism of white feminists – people actually went back and began to redo work - and to rethink that work non-violently . . . can we look at any other radical social movement and talk about how they went back to the table and said "the way we were constructing our theory was inaccurate and we have to change it?" (*hooks March 1, 2014)

This is the additive value that a feminist participatory action research approach brought to the virtual community: feminist knowledge helped make analytic and political linkages across disparately marginalized and unequal places, groups and relations (Kim 2007). It linked and validated evidence/feminist scholarship with the need to act to apply this knowledge. It showed that good scholarship can and needs to be politically engaged.

Yet while feminist action research was being realized, it was not achieved through equal participation. I was involved in a particular form of engaged and leaderly scholarship. I had thought that participants would want to investigate specific issues and bring the products of their reading, investigation and learning to the community. Instead

they were content to be guided in the exploration, to be presented with a wide range of evidence and to bring their experience to it. I therefore had to guide, inspire, facilitate and foster participatory knowledge building practices and the social responsibility to act.

5.6 Conclusion

In this research, a virtual space was created as a context for knowledge construction and consideration of action, by and for diverse people working on substance use issues in Canada. The virtual community was designed to support understanding of the operation of gender and other determinants of women's health, and to catalyse action towards improved treatment, prevention and harm reduction initiatives that are gender- and trauma-informed. As such it served as a forum for increasing awareness of multiple forms of evidence on women's substance use, as well as enhancing the epistemological credibility of those who work on women's substance use research, treatment and policy.

The community was a conscious effort to enact and examine feminist participatory action research in the online environment. Progress towards the realization of FPAR principles was examined: (i) how/was *gender inequality* discussed, examined and synthesized, (ii) how/was *participation* enacted, (iii) how/were *inclusion* and diversity handled, and (iv) how/was *action* conceived and enacted by participants.

The community did offer the opportunity to discuss, examine and synthesise the workings of gender inequality in the addiction field. Identification and discussion were possible relating to: the suppressed needs of women substance users; programming that exploits instead of transforming gender inequities; and the operation of willful ignorance of sex and gender in the field. This naming of the resistance to gendered approaches had the benefit of evoking empathy and respect for each others' work and collective envisioning of how we might work differently. It invited the valuing of multiple forms of evidence and thereby challenged the stance that exposure to strong research evidence will be an adequate foundation for learning and for developing addiction policy and practice. It offered evidence from multiple disciplines of research, practice and policy, from nursing, sociology, psychology, neurobiology, social work,

education and so on. The process of examining gender, race and other dimensions of marginalization and inequity in the addiction field underscored how knowledge production is a communal endeavour, involving acknowledgement of experience as well as other forms of evidence. As with early consciousness raising praxis, experience was linked to the experience of others and to other forms of evidence and to larger theory, in order to identify what needs to be transformed. In this way experience was not essentialized but collectively interpreted, to become a source for transformative agendas.

The community afforded many participatory opportunities: for voicing of experience, listening, active learning, acknowledging and validating of others, and for making links between ideas and between research and experience. The value of a communal space was made visible, in how it supported listening and 'response-able' knowing, response-able both within the community and more widely. Participation was enacted on both intellectual and affective levels. On the intellectual level participants engaged with how gender bias and structural inequities operate in their various contexts for women with substance use problems, for themselves as practitioners, and through the academic literature. At the same time participation went beyond engaging with various social, political, cultural and economic inequalities arising from participant experience and from the literature. It also allowed for appreciation of others, empathy with what others have encountered in their practice, including the feeling of inequities. This type of affective participation has been identified by feminist activists and epistemologists as essential for critical practice.

While consciousness raising and the integration of experience have been exemplary contributions of feminist theory and practice, FPAR's principle of inclusion was of fundamental importance in the design and leadership of this community of inquiry. In the inclusion of researchers, practitioners, policy analysts and educators, a leveling of epistemic privilege was made possible and the potential enhanced for linkage across the disciplines and sectors needed in the transformation of the addiction field. The further intersecting inclusion(s) across race, remoteness of location, workplaces and provinces/territories achieved, served to widen the purview of the discussion, to reduce the isolation of those involved, to disrupt discouragement about agency to act, and engender hope about what is, and might work. The work of the

community in collective SGDBA, also prompted a widening of the lens from women's substance use as 'the problem' to consideration of how racism, poverty, structural violence against women and other systemic forms of discrimination are at play, and the identification of more inclusive, comprehensive and nuanced responses. A limited reciprocity is possible in such communities, but it was possible to make difference a resource, to see the partiality of each person's perspective, yet the power of the cumulative perspectives, knowledge and evidence. This virtual community with knowledge translation goals provided opportunity for diverse participants to engage in the discussion of structural roots of substance use and addiction as problems, with the complexities of SGDBA, and even to experience equanimity in a shared 'oppositional consciousness'.

A litmus test of feminist participatory action research is that it evokes action and social change that improves the conditions of women's lives. Initially, from the findings in the focus group held eight months post community it appeared that significant action in the form of social change was not an outcome. But with further analysis of the all the material from the sessions, from the discussion guides capturing the content of sessions, and the follow-up focus group, it appeared that considerable knowledge seeking, describing what exists, and sharing of learning took place throughout the span of the community and post community. Action in the form of analysing current praxis and envisioning what should exist was also apparent throughout. We also had the opportunity to act as engaged scholars in collectively synthesizing the literature and comparing it with daily clinical practice and policy making in the field and seeing how systems of domination were in play. The opportunity to act in this way as scholars by doing collective data collection, analysis, synthesis and formulation of ideas for application to practice and policy is an important part of FPAR. All of this activity may well be the foundation of future actions that result in paradigm shifts large and small, and in broader social change.

While we acted together as engaged scholars within the community, facilitating that equitable participation required considerable planning and research before the meetings, and more leadership and facilitation within the meetings. Thus, in this aspect an idealized version of FPAR – with equal participation approximated - was not realized. I needed to learn how to facilitate learning in community and the conceptual

use of research, beyond the narrower goal for knowledge translation of absorption and application of information only. And I needed to facilitate learning that prompts the capacity to embrace wider paradigms for practice, by diverse adult learners, in the online environment. The next two chapters describe this learning, how it was applied in the context of the community and what transformative and online learning lenses have to offer virtual communities as locations for catalyzing research to praxis.

Chapter 6 – Applying situated and transformative learning lenses

In this chapter, the activities of the community created in this study are viewed through the lens of social learning theories and their application in communities of practice and other forms of learning communities. Two areas of learning theory - situated learning theory and transformative learning theory proved relevant, given my interest in collective examination of evidence that could foster paradigmatic shifts in the approach to practice in the addictions field. This chapter begins with a consideration of situated learning theory and its application in communities of practice as a potential foundation for implementing online communities with knowledge translation goals. How this study's community worked with CoP principles and practices, and how it diverged from these practices is considered. The second half of this chapter considers what the principles and practices of transformative learning add to community-based learning where adults have the opportunity to examine, critically reflect on and collectively synthesize evidence, and thereby became open to new perspectives.

6.1 Situated Learning Theory and Communities of Practice

Social and situated learning theory and practice have had prominence in the adult learning field in the past decade. They are particularly relevant to this study, as often knowledge translation has been viewed and enacted in a more limited way with a focus on transmission of information, rather than viewing this process as 'learning'. In the previous chapter, the *social* context of learning has been well demonstrated in the case of the collective sharing and theorizing in women's consciousness raising groups and in feminist pedagogy more broadly. Wenger and colleagues (Lave & Wenger 1991; Wenger 1998; Wenger, McDermott & Snyder 2002) have explored the concepts of social learning, situated learning, community, participation, reflective practice and identity - all of which resonate with feminist practice. And as mentioned in the introductory chapter, Palmer and Kramlich have noted that communities of practice can provide "the ideal conceptual framework for knowledge integration and translation (2011, p. 32), that can move beyond knowledge dissemination alone to support

"managing the conceptual, instrumental and strategic use of knowledge" (p. 32). While Wenger had initially focused on social learning *within* an organization, researchers have explored the use of communities of practice in the health field as a form of interagency and inter-professional working as well as at the systems level (Bentley, Browman & Poole 2010; Kislov, Harvey & Walshe 2011; Lathlean & Le May 2002).

Wenger and colleagues have defined communities of practice (CoPs) as "groups of people who share a concern, a common set of problems or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger, McDermott & Snyder 2002, , p. 4). I was interested in CoPs as new forums for collective learning where people could collaborate directly, use one another as sounding boards, and teach each other (Brown, JS & Duguid 1991). In this research, it was of interest to see how/if benefits in learning and agency could be achieved through interacting in a community of practice which met on a short term versus an ongoing basis. Further, could a multisectoral group working across distance, as opposed to those from one profession in a workplace, as often described in the communities of practice literature, be held together by a common sense of purpose about extending their practice related to gender? Might this CoP with multisectoral participation and co-learning goals serve as a model for knowledge translation on complex health issues?

Three core aspects to CoPs are considered here for their relevance to creating online forums for collective learning and fostering of action to address inequities in women's health: a) participation, mutual engagement and practice, b) identity and c) community.

6.1.1 Participation, mutual engagement and practice

In situated learning theory, participation and practice in collective learning processes are central concepts. Participation in CoPs has two elements: it involves both taking part and exchanging and connecting with others (Handley et al. 2006). Mutual engagement makes possible the ability to negotiate meaning and create shared meaning. The following quotations illustrate members' initial thoughts about participation:

> *for me, aside from having an opportunity to learn and understand more about an area that I'm just interested in as a practitioner in the field*

> *the biggest thing that I'm going to take away to be able to share with others is that it's just a sharing of experience and of wanting to be able to talk about issues and concerns, so I think we'll be able to draw a lot more people in.*

Participation in the workplace-based communities of practice which Wenger initially studied was face-to-face, took place over time and was oriented around solving common problems related to specific workplaces. Others who have studied CoPs across agencies have looked at aspects of participation and practice such as membership, commitment, relevance, enthusiasm, infrastructure, and skills in accessing and appraising a variety of sources of knowledge (Lathlean & Le May 2002). In this *Gendering the National Framework* CoP, the engagement was virtual, short term (over 6 months) and not fully realized, in the sense that not all participants attended every meeting. However the limited participation did still surface elements of active knowledge sharing, and combining and bridging of ideas. The following quotations illustrate this active knowledge sharing, comfort with sharing ideas, and significant linkage of ideas being made:

> *and it's just really important for people to learn from each other's experience and recognize that, not only does it make sense sort of theoretically, but that you actually did notice very specific positive things, like better retention. Like, that is the -- you know -- the absolute, you know, crux of the issue that a lot of people are facing*

> *I think that one of the problems that we get into is our own language. I think we should stop talking about addictions and talk about substance use, and this is a substance-using society and not everybody who we deal with is addicted, and certainly, with respect to alcohol, anyway, most of the problems are caused by the non-addicted people, who binge drink or whatever else..*

> *when I think of the most heated discussions I've ever had about harm reduction with people, it's usually because their definition is so narrow. So, usually to me, either needle-exchange or methadone. But I once read a definition, and I'm just trying to find it here, where it talked about harm reduction as 'mechanisms and policies that reduce risk not only to the individual user but to the surrounding family and community.' And I thought if -- in -- you know, publications and that, if the definition is a broader definition that's more palatable and we, you know, in all our different organizations work to make that happen*

There are examples of CoPs that illustrate how participation can be marginal and still have benefits of mutual engagement, learning, connectedness and identity development (Handley et al. 2006). Indeed legitimate peripheral participation is a

concept explored in the literature on communities of practice (Fuller et al. 2005; Lave & Wenger 1991; Wenger 1998). In the case of the community which is the subject of this study, it seemed to be less about peripheral than about eager participation; and thus it could be seen to be a "fast" community (Roberts 2006). The sense of being involved together in learning about gender-based analysis, the shared examination of power relations in the larger substance use field and the appreciative tone set, all served to support participation regardless of how many meetings one had attended, or what work role a participant currently held (service provider, researcher, policy analyst, educator, community activist). As one participant noted about mutual engagement:

> *how do you bring a gender lens to treatment? As to harm reduction and prevention and policy -- we really feel that, the same as the women who come to the Enhanced Services for Women program, is that a lot of times what we need to do is come in like we are this morning and just talk about it.*

The practice characterizing this study's CoP could be described as collective engagement in sex-, gender- and diversity-based analysis (SGDBA). The community was designed to promote development of this practice through having the opportunity to hear others describe their application of SGBDA, engage in discussion, try out ideas, and then to adapt their own practices beyond the community. In this case the link to action or agency in their daily work was critical: that the CoP become a site for development of an activist identities and practices not only within the CoP, but in their many workplaces, and in other local, regional, provincial or national committees and communities in which they might be involved, both during the span of the study and beyond. A presenter on her work in developing alternating gender-specific treatment cycles for adolescents, encourages others:

> *You know -- and I'll just caution you. . . . we've had centres say to us, "We can't rotate gender" -- initially. "We can't rotate gender because we've got such a high male basis of staff" and there's other considerations with adolescent treatment, you know, in terms of staff ratios and things like that. So it is a -- it is a science to make it work with all the other legal requirements but it -- but it can absolutely work.*

A comment was made at the end of this session as to how much the participant appreciated learning about this application of gendered practice, and having the opportunity to discuss it.

It was interesting how harmonious the interaction was. While aware of Larson's caveat that communities of inquiry need facilitators/ participants with "capacities and skills in engaging in deliberative and difficult conversations" (2000, p. 312), the conversations in this community were not, in essence, challenging. Participants seemed keen to learn about what each other knew and had tried; to be interested in "the experience of knowledgeability" (Wenger 2010, p. 3) on gender, women and substance use, from an appreciative and not a competitive stance. There existed a sense of release from their usual work, and a view of the web meetings as precious, non-regulated space for learning and resistance. As one participant commented:

> *and also being able to hear from women across the country about programs that they're involved with in such an immediate and intimate way, where I can ask personal questions is really a helpful format for me.*

A key aspect to participation in CoPs is their voluntary nature. In this and other virtual CoPs I have convened, it has proven important to maintain the voluntary, participatory feel to the community, to make the CoP a go-to place for updated information on gender, to support curiosity about gender-based analysis, and to discuss what is known without a preconceived direction for action. In this way the community does not become a platform for enforcing a view, but a place for collective and equitable inquiry. From this perspective having a shared repertoire, - not only the shared knowledge and language of the substance use field, but also the shared engagement in the first section of the community (where evidence was presented) - was important. Having a shared repertoire and the opportunity to hear a common presentation of evidence at the beginning of the web meetings accelerated the knowledge exchange and leveled the difference in knowledge base across participants. This formalization of teaching/learning could be seen as one point of departure from a traditional CoP, often more firmly rooted in exchange of experience to solve a common workplace problem. My participation as convener, researcher and facilitator for the CoP as a whole, and of the first section of each web meeting, was also a differentiating element. This role as convenor and facilitator of the CoP as well as a known researcher on women's substance use was a significant element to the online community of practice, bridging it to knowledge translation and to development of identity through participation. As one participant noted:

> *And also I think your reputation Nancy also is, you know, and other folks have mentioned, a real drawing card, but also is as like a ripple-out effect, so when I*

send materials that I think might be useful, and I say "Well, I'm participating in this research group and study cohort under Nancy Poole and they've prepared some power points with her and her colleagues to present us" that's quite meaningful to other folks who again wouldn't have this necessary opportunity or chance to participate. So it really has that kind of rippling effect that I've appreciated.

6.1.2 Identity

In situated learning theory, learning is seen to be about practice and identity development, not only acquisition of knowledge (Wenger 1998). "We define who we are by the ways we experience our selves through participation" and "by negotiating local ways of . . . manifesting broader styles and discourses" (ibid, p. 149). Through a trajectory of participation, joint enterprise, and a shared repertoire, community participants can develop and extend knowledge and skills, see the values they share, change attitudes, and develop or reinterpret one's professional identity (Kislov, Harvey & Walshe 2011). One participant noted:

We're all doing their thing locally but if you actually get together regularly and establish relationships, it becomes a great brainstorming capacity. You can't predict where it'll take you, but without it we remain pretty isolated.

In developing our knowledge and practice, we come to further understand who we are, in what communities we belong, and as such "form, repair, maintain, or revise" our perceptions of self (Handley et al. 2006, p. 644). As Handley and colleagues describe, participation in communities of practice can involve identity negotiation that differs from the identity regulation undertaken by the organisation for which one works, and from other non-work identities. "As such learning is not only about developing one's knowledge and practice, it is also involves a process of understanding who we are and in which communities of practice we belong and are accepted" (Handley et al. 2006, p.644). In feminist consciousness raising groups it was important to find and work with others interested in resistance against the status quo of the institutionalized operation of gender. In the groups such as CoPs, participants are able to further develop knowledge and activism "through processes such as role modelling, experimentation and identity construction (Handley et al. 2006, p. 647) Extended identity that surrounds one's professional identity is subject to modification as the result of increased knowledge and skills and widening fields of work (in this case on sex/gender- and diversity-based analysis), as well as changes in attitudes and values, or reinterpretation

of old ones. As such, identity is what people bring to the community; it is further mutually defined in CoPs; and it also becomes an output (Thompson M 2005). The participant cited above goes on to identify how the relationships with like minded people in communities of practice help create momentum for activism on gender issues, when otherwise she and others would be working in isolation, and the perception of gender as a small issue would be perpetuated.

> *It's sort of like creating a social movement, very, very early days of that process. But I think relying on like-minded people but working in relatively, in effect isolated, because on any issue that's small – I mean it's large but it's perceived to be small…So without that regular contact you're just not going to build any momentum for change."*

Wenger sees communities of practice as ongoing or living contexts that can give people access to others with competence in a certain area of practice, and can also "invite a personal experience of engagement by which to incorporate that competence into an identity of participation" (Wenger 1998, p. 214). In the case of this study's community, such an extent and type of participation was not the aim, given the limited time frame of the community and the fact that people would for the most part be enacting competence in SGDBA outside the CoP in their distributed workplaces. However, as seen in Chapter 5, active participation was in evidence, as was increased consciousness of gender issues and of themselves as agents in the application of gendered approaches in their workplaces. As well as through examining evidence, sharing experience, and discussing and critiquing both, this was achieved through identifying with others who had been successful in promoting and acting on gender issues. For example, in the quote below a participant could not only see how another participant was successful in integrating a women-centred, principle-based approach in the contested area of women's use of alcohol when pregnant, but she could see how a principle-based approach (versus a more instrumental application of evidence to practice) could be applied in their own setting.

> *And that's why I was so glad that you mentioned those principles [of women-centred ways of working with women who use substances in pregnancy] in it, because to me those principles are really helpful and can be adapted for us all, that idea of flexible and accessible, holistic, let's practice collaborative harm reduction. I mean, that's straightforward. I mean, for us to all think about, well, what -- what does that mean in our context?*

It was helpful that the participants shared that they had comparable kinds of discussions in their workplaces. The workplace interactions illustrated that one does not have to be certain about what to do before entering into the discussion, instead it can be within open dialogue that we learn what action we might take.

> *And we've had some really interesting discussions here [at a provincial level], you know, in the act of creating this group of advocates, you know, it's really called upon us to have these discussions with ourselves. I mean, where do we come down on decriminalization, and, you know, legalization, et cetera? So it's been kind of fun to have some of the debates, because it helps all of us to clarify to what -- what we need to do at this point, not only in the treatment system but in [sic] the policy level as well*

Wenger identified identity enactment and development on multiple levels: as negotiated experience, as community membership, as a learning trajectory, as a nexus of multi-membership in various CoPs and as a relation between the local and the global (Wenger 1998). Like the spontaneous coming together of discussion and theorizing of consciousness raising groups, this potential for identity formation in the context of community, inspired and guided the planning of the community. My goal was to foster extension of professional identity through engagement in SGDBA, through widening participants' reference groups beyond their individual workplaces, and promoting change in attitudes and values about the need to act on gender issues in the substance use field.

While these core concepts related to communities of practice (of participation, practice and identity development) were helpful in the community design, it is important to note that some key indicators of a CoP as identified by Wenger were not in evidence in this community. These include sustained mutual relationships and mutually defining identities (Wenger 1998, p. 125). This was not a community with the goal of inbound trajectories from apprentice to expert, or from peripheral to more central participation. The opportunity for participation was minimal (participation in five meetings and a focus group). Participants might have come to see their experience within a CoP on gender-based analysis and practice as important, or not, to their overall identity as a person working in some capacity in the substance use field. The experience in, and identification with, this community might more likely be the seed for acting on this knowledge *in other contexts*, either in a proactive way in their workplace or as new opportunities for raising awareness/action on gendered approaches emerge.

6.1.3 Community

Some experts in designing environments that can support social interaction see that the term "community" is at risk of losing its meaning (Barab, 2003, p. 197). In this case perhaps due to the term being a "warmly persuasive word" (Williams as cited in Duguid 2005, p. 109), and due to growing awareness of CoPs, it appeared that the term 'community of practice' helped attract people to participation and to conceptualize themselves as working or learning together. The comments made in the opening session evidence this:

> *So am pretty excited to be involved in this virtual community of practice, very interested in online learning and e-learning and that kind of thing, so this is multi-level learning for me.*
>
> *So I'm excited to be here and I'm really very interested in this virtual community of practice and what we can learn from each other.*
>
> *And I'm looking very forward to the different comments and the different ideas across Canada and I'm really excited and glad to be a part of the community*

A key element of CoPs is the sharing of tacit as well as explicit knowledge (Duguid 2005). The safety to share tacit knowledge and to engage in core community processes such as the processes of negotiation of meaning and of further development of a shared repertoire requires a sense of cohesion or alignment with the community. The following quote by a participant in the post-community focus group shows that this CoP, while offering elements which were supportive of a sense of community, did not create quite enough safety and sense of cohesion for her; and that in fact no all-virtual context may have been able to achieve this.

> *Yeah, I would second that in that you know my experience in other kinds of blended experiences have been that generally there is that sort of cohort face-to-face meeting first and it does and from my experience increase participation in subsequent meetings. I think one of the things that I have found helpful is from people that I do happen to know in this virtual community practice to sometimes you know, and I don't know, it's kind of interesting because sometimes I would have, you know, maybe five conversations in a chat area, which were helpful to help me kind of explore different areas, but that part about building cohesion in the initial part is really important and so the fact that you on this particular format, Nancy, had areas where we, you know, we had a homepage or a webpage that we could go to and share information, that was a good idea. I would have probably, you know, wanted a little bit more facilitation in that*

> *initial piece, that initial maybe month or two so that there was a greater sense of cohesion being built, and that would have invited me or made me feel a little bit safer to share in more detail at some point.*

This participant notes how the web links on the landing page of the CoP's collaborative virtual space were helpful. How CoPs are located within larger contexts of online information access and public pedagogy; and how this affects learning is an aspect of situated learning in communities of practice that is not discussed to any extent in the literature. Links to the websites of women-centred programmes and to grey literature that provided rationale for women-specific interventions, or critical analysis of existing gender blind approaches were made available to the CoP participants. Occasionally links to recent media coverage about women and substance use or the exclusion of women within the discourse on substance use were posted. Such external linkages provided the opportunity for individual exploration and learning; and in some cases prompted discussions within the community initiated by participants who wanted to share their critical appraisal with the community, or who sought the community's analysis. Sandlin and colleagues (2013) propose that engagement with public pedagogies (in the form of popular culture, informal educational institutions and public spaces, dominant discourses, and public intellectualism and social activism) has the potential to foster critical learning with implications for transformational learning, identity development, resistance to dominant cultural messages, and the role of the progressive educator in supporting critical media literacy.

Also from the quote above can be drawn what Torraco (2002) describes as the paradox of nebulousness of communities of practice – the challenge of needing some level of structure and leadership to convene and foster CoPs and at the same time to maintain their organic, informal and communal nature, where participants can find for themselves a meaningful level of participation and connection for collaboration. It seems possible, as Thompson has advocated, that the use of structure in CoPs can be done in such a way as to indirectly "seed" (2005, p. 162) future collaboration, even if this is not achieved in the short term. A requisite balance between some level of structure and informality, and between a convening function and the development of agency and/or collaboration on the part of participants is both definitive of communities of practice, and difficult to achieve and maintain.

While this virtual community drew from situated learning theory, and while evidence of some key aspects of communities of practice were evident, is there another term that might more accurately describe it? Various other conceptions of learning communities which explore the structural and other balances and contradictions described in the previous paragraph have been discussed in the literature. Seaman (Seaman 2008) uses the term 'knowledge community' to refer to communities that can be created formally (as this one was) versus being naturally emergent. He sees the goals of the work in knowledge communities as not necessarily collaborative and possibly simply cooperative. In knowledge communities, participants have a shared knowledge base, not necessarily a shared practice. Knowledge communities can have distributed participation and can have a focus on both acquisition styles of learning as well as participatory ones (Paavola, Lipponen & Hakkarainen 2004). The emphasis is on processes for transforming prevailing knowledge and practices, and creating knowledge. Peters and LeCornu use the term 'learning circles' to describe communities that build on situated learning concepts but that are structured and facilitated rather than evolutionary and self managed; and that have an explicit focus on creating opportunity to learn, rather than a focus on indirect learning arising through participation. The limitations of such structures are potentially that they support accumulation of knowledge, or a recombining of knowledge that does not necessarily lead to innovation, resistance to prevailing hegemonic practices, or activism on contested issues such as gendered approaches to substance use and health.

Many authors have used the term 'learning community', to describe cohesive communities engaged in collective learning (Rogers 2000). Communities of learning that are spaces for reflection on oppression, inequality and exploitation have been advocated by Humphries and Martin (2000), who are concerned with how critical pedagogies are enacted and marginalized voices can be adequately heard. Using the term 'communities of inquiry' Larson (2000) picks up on this identified need to consider issues of difference in learning communities. She speaks of scholars and practitioners needing "skills in engaging in deliberative and difficult conversations with an intent to understand, to learn and to use this knowledge to design more responsive educational systems" (p. 312). She and other education system leaders see the possibility of creating space for deliberative practice within communities of inquiry that work from values of support and collaboration to solve more "intractable problems".

Such conceptions of communities of inquiry address concerns of how power dynamics of communities of practice may not be well enough conceptualised (Herbert 2005; Li et al. 2009a; Roberts 2006) and the realities of communities undertaking collective learning that are less oriented to developing practice within a specific workplace, but to deliberation about broad and complex social issues (Burgh, Freakley & Field 2008). Thus this term of 'community of inquiry' over 'community of practice' may be more apt for the community created in this study, and for future communities with goals for knowledge exchange between researchers and clinicians, policy makers and people with experience of complex health issues, as it captures the essence of 'community', the respectability of 'inquiry' and the broad scope of the topics for inquiry and action.

In this discussion of CoPs, communities of inquiry and other forms of knowledge communities, it can be seen how important the concept of 'community' can be to attracting and motivating people to participate. In this case study, the use of the term CoP provided a hook, and the core principles and elements of CoPs form a ribbon throughout. At the same time it can be seen how the "structural components of the dynamic underpinning of CoPs" (Thompson 2005) have not been adequately discussed in the CoP literature. Thompson described the need for boundary objects (documents, terms, concepts and other forms around which the community can organize their interactions) to support communication and innovation. The focal concepts of sex-gender- and diversity-based analysis and the infrastructure of the CoP supported learning and identity development in non-prescriptive ways. Making systemic oppression and participants' ideas visible, creating the opportunity to speak of one's perspective to others, to link it to broader trends, and to absorb feedback (ibid. p. 163) were critical. In the next section of this chapter additional educational elements - beyond a core CoP approach - which are offered by transformative learning theory are examined for their potential to add to the understanding of how community participants might be assisted in overcoming inherent resistance to change, and be supported in the kind of shift in knowledge, attitudes, perspective or identity, that might seed or catalyse action on gender.

The community of practice literature was very helpful in designing this virtual community. The term CoP in and of itself was seen as inviting to the participants. The community achieved some of the mechanisms for success for CoPs identified by

Ranmuthugala and colleagues (2011, p. 3) including: facilitating access to expertise not available locally, providing the opportunity to discuss work related problems in a non-judgmental environment, facilitating access to experts, facilitating knowledge exchange between members, and alleviating of a sense of professional alienation.

Some differences from CoPs emerged in the building and enactment of the community. Some of the challenges which have been identified in the literature related to CoPs (Roberts 2006) were worked with in different ways. As examples: a distributed and multisectoral participation that involved a valuing of different forms of knowledge was enabled; leadership and facilitation was consciously enacted; a short term time frame which addressed a key barrier to knowledge seeking and community involvement was employed; formal and public sources of knowledges, as well as tacit knowledge were integrated; and the broader social and cultural context in which the community was embedded was consistently acknowledge and critiqued. Both the time factor, and need for knowledge building that can support change in perspective/commitment to action on gender were of key importance. In the context of current workplace structures and fast paced informational environments, a long term and open ended commitment of time, characteristic of communities of practice was not feasible for participants. Others have confirmed this finding about the potential for substantive knowledge translation within communities: Paavola and colleagues (2004, p. 568) discuss how in these times, communities can "create new knowledge, artifacts and practices collaboratively, in mediated processes of activity" and "expansively" new knowledge, substantially beyond current conceptions and practices. It is such culturally new practices about gender, and related knowledge models that could be used post community, in future applications to practice, that was the goal for this community and as a potential model for virtual knowledge translation on complex health issues.

Beyond what the community of practice literature offers about the validity and processes of social learning, I explored what the literature on transformative learning had to offer about how to support change in overarching perspectives. I saw this as potentially additive to learning in community, to proactively support a perspective change such as coming to see the importance of gender-based analysis and action on gendered responses.

6.2 Transformative Learning

> *Transformative learning theory and practice-based learning theory both offer compelling but distinct accounts of adult learning.* (Hodge 2014, p. 165)

Brookfield sees transformative learning as involving "a fundamental questioning or reordering of how one thinks or acts" (Brookfield 2000, p. 139). I was looking to: create a space that helped organize the emerging information available in the substance use field on gender and social determinants of health approaches; support collective examination of this evidence in a way that linked it to other forms of evidence; contextualize it in the larger practices of the substance use field; and promote some element of synthesis, reorganization and dissonance for the participants. The work of Gardner (2008) resonated: that the 'synthesizing mind' is one of the 'five minds for the future', and that multi-perspectivalism can be one route to the elucidation of an issue (p. 71). While the community of practice literature provided the container for social learning in groups, and the feminist action research literature contributed the emphasis on diverse experience as generative of evidence, the transformational learning literature served to support understanding of how to help people move beyond collective engagement and learning, to innovate and to consider new paradigms for service delivery and policy. The *evidence* related to sex/gendered approach to substance use was not shifting the field in and of itself, nor was the suffering of women and children facing gender-based violence, poverty and substance use problems. It seemed the field needed the chance to engage with the evidence(s) in a legitimate yet resistive or disruptive way. A paradigmatic change towards gendered approaches was needed, such as was in progress with shifts in the field to see substance use as a public health concern and harm reduction approaches as legitimate and important components of a continuum of interventions.

Transformational learning has early influences in the concept of paradigm shifts and in conscientization and critical theory (Mezirow & Associates 2000, p. xiii). This current project seemed an opportunity to balance cognitive engagement, as enacted in more traditional learning and knowledge translation approaches, with the creation of a location for examination of evidence from a critical lens. Such a location could support deep examination of context and questioning of the current paradigms of response to women's substance use, to in turn prompt a transformation in participants' frames of

reference. A community working from a transformative learning foundation could move beyond examining the evidence and the discourse about women and substance use, to consider the dissonance between this evidence and the discourse/policy/practice in operation related to women's use, and to wrestle with the actual and potential paradigms for responding, and how to act. Mezirow called this process *perspective transformation*, to gain a "more inclusive, discriminating, permeable and integrative perspective" (Mezirow & Associates 1990, p. 14).

Overall, transformative learning theory provides a description of the dynamics of the way adults learn to negotiate meanings, purposes and values critically, reflexively and rationally. Recent work of some transformative learning theorists offer ideas about the relational context needed to support transformative learning. The following three subsections of this chapter which are concerned with spaciousness for reflection, synthesis and validation, illustrate how some of these key relational contextual elements of transformative learning were enacted.

6.2.1 Creating space for reflection

Transformational learning theory is explicitly concerned with "the process of using a prior interpretation to construe a new or revised interpretation of the meaning of one's experience, as a guide to further action" (Mezirow 2000, p. 5). Mezirow describes transformational learning as the process by which we "transform our taken-for-granted frames of reference (meaning perspectives, habits of mind, mind-sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action" (Mezirow 2000, pp. 7-8). To achieve such shifts in perspective, space for discussion and weighing of evidence and assumptions is needed, as well as trying on of alternative perspectives

Not only objective, but subjective reframing is required. Subjective reframing can involve critical self-reflection on one's assumptions about a narrative (i.e. connecting someone else's experience to your own) or critical reflection about a system (as in consciousness raising). Critical theorist Giroux is explicit as to the systemic and political focus of critical reflection, inviting educators to think about "what kind of

educational work is necessary within different types of public spaces to enable people to use their full intellectual resources and skills both to provide a profound critique of existing institutions and to enter into the public sphere in order to interrupt the operations of dominant power, and fully address what Bauman calls the 'hard currency of human suffering" (Giroux 2003, p. 97).

Transformative learning theorists and practitioners have identified multiple frames of critical reflection – content reflection, process reflection and premise reflection - that support development of new meaning (Cranton 2002; King 1997; Mezirow 1991; Mezirow, Taylor & Associates 2009; Taylor 2009). In the case of the community that is the subject of this research, content reflection comprised consideration of the data available about women and substance use, the paradigms operating in the field, and how those affect the response by the field. Process reflection involved consideration of the adequacy of the data we have available and other possible interpretations. Premise reflection, albeit more limited, involves reflection on underlying premises and assumptions. All three types of reflection have the possibility of creating openness to understanding inequities and support interest in action.

The creation of the conditions for transformative learning were attempted through the design of the meetings as follows:

- In the first phase of the meeting an opportunity largely for content reflection - evidence was presented about a broad topic related to women's substance use through a range of methods: prereading, a powerpoint presentation of research evidence, and/or a presentation by community member on practice evidence
- In the second phase of the meeting an opportunity for content, process and premise reflection through discussion, posing of questions, and/or modelling of critical reflection.
- An asynchronous web workspace was also made available for accessing weblinks to international programming and reports, background reading documents, the meeting powerpoint presentations, and a discussion forum (for participants to contact each other for further discussion).

The participant quotes below indicate how these elements generated critical reflection.

Notably, the discussion guides paralleled the reflective community process: each of the four discussion guides (Appendix 3) include:

- A short background, contextualising the topic
- Presentation of issues, evidence and implications for practice and policy
- Examples of promising practices in action in Canada, (at different levels of prevention and treatment, harm reduction, policy)
- Discussion questions
- Weblinks
- References

Taylor (2000) discusses how the literature has granted cognitive learning and critical reflection too much importance and has not given enough attention to the significance of affective learning. It was interesting, as can be seen in the quote on the next page about treatment of pregnant women, how often emotions of relief and laughter were expressed following critical appraisal of the practice and policy in the substance use field. In this community of inquiry I integrated elements of an appreciative inquiry approach to elicit feelings, particularly feelings of solidarity, hope and enthusiasm for how things were working or might work well. Others working from a participatory and action research based approach have applied an appreciative reflection approach, which they describe as combining "reflection and appreciative action to bring a focus to actions that amplify success" (Ghaye et al. 2008). Nova Scotia based adult educators, Cockell and Blair (2012) blend appreciative inquiry methods with collective adult learning approaches to support reframing of experience, and to foster action through seeing how a future can unfold from a present context. The other purpose of bringing in appreciative inquiry was to avoid, as Brookfield has described, "an energy-sapping radical pessimism concerning the possibility of structural change" (Brookfield 2000, p. 145) which he sees as possible in the process of critical reflection that brings to light existing power relations and hegemonic assumptions. The impact of the deliberate appreciative stance of focusing on what is and what might work well was not directly assessed, but may have contributed to the lack of discord in the community. The affective element of the learning experience, particularly its affirming function is addressed further below in the "Validation and Sanctuary" section.

A wide range of outcomes related to perspective transformation have been found such as: revision of belief systems, increase in personal power, compassion for others, creativity, a shift in discourse, courage, a sense of liberation and a new connectiveness with others (Taylor 2000). The following excerpts from the dialogue within this community's meetings show how participants had the opportunity to voice and reflect on the assumptions in operation in the substance use field and their own work, and illustrate some signs of potential shifts in beliefs, perspectives, compassion, connectedness, and commitment to activism. Extensive questioning took place of broad assumptions and approaches operating in the substance use field. In the quote below what is being pointed out by a participant is how the substance use field often misses pregnant women's priorities related to their needs and holistic goals in pregnancy, and instead operates from a narrow, proscriptive, addictions agenda, which is disempowering rather than empowering.

> *Yeah. And having that sense of -- you know, that one quote really stood out for me, about, you know, how the woman felt like she wasn't pregnant while she was there [in treatment for substance use problems]. I mean, we've siloed things so much, you know. We often do that. We feel like we're delivering an addictions program and we forget that, you know, that's it -- you know, we forget that basically, you know, probably the pregnancy is the prime -- primary thing going on for her. (laughs)*

The voicing of how the field has missed critical gendered influences on women's substance use, is also captured in the following quote by another participant, with the word "major" notably repeated.

> *And the experience here at the women's centre as well has taught us that, you know, poverty is a major, major factor in a woman's sense of freedom to leave a relationship because, of course, it often involves being able to pay for her own lodging and take care of her kids on her own, financially.*

Another instance of reflection on the way we approach service delivery overall in the field came through a point about how a wider range of health professionals might deliver substance use interventions. In this case the potential was identified for expansion in the breadth and efficacy of what the field offers, if we bridged to quite diverse practitioners such as dental hygienists, who had in one instance demonstrated interest in and compassion for women's treatment needs.

And not -- you know, just in general for pregnant women but also around substance use issues because they see a lot of women with quite serious substance use problems whose gums and teeth are very much affected. And they [dental hygienists] were so interested in learning how to use brief motivational interventions with these women, both the ones who were pregnant and the ones who have serious gum problems that they're concerned might be related to their substance use issues. So, you know, it's funny how -- I think it's a profession that has a big role to play if we can -- if we can connect them.

In the session about girls and substance use, reflection took place on our assumptions about what adolescents need and our practice with them, particularly as to how the field views young women as needing changing (versus assisting). In the first instance I mention Giroux's work and appreciate how the work of the treatment centre designed for young Aboriginal solvent users is consistent with the respectful approach to youth that he sees as important for learning and agency as citizens.

Yeah. I've been reading, as a part of my graduate work, some of the work of a -- of a professor at McMaster University called Henri Giroux, and . . . he talks a lot about how we -- you know, we view youth so negatively that we're kind of coming in as a society, thinking we've got to change them, that somehow they're wrong and that, you know, they're a problem, and that we have to get them on the right path, kind of thing. And it just sounds like such a different approach that you're talking about here, of just honouring who they are and pulling out, you know, their -- the best of what it is to be a kid, instead of seeing them as somehow having to get on the path to quote 'responsible adulthood' or whatever, right?

Another participant expresses empathy for the complexity of the pressures on youth, their uncertainty in the face of these pressures, and the implications for how we offer support.

And I feel, you know, kind of passionate about this from the perspective of remembering what it was like to be (laughs) a young adult and reeling with a -- lots of pressure to use substances and not really that sure of, you know, in -- my own life about how to make decisions about that. You know. I don't know how we -- how we do it in a way that is really helpful

Another participant brought in how the larger public discourse on drug taking and risk taking by young people is operating, and how it contains critique from youth.

Can I just pick up on that? In the latest edition of Maclean's[11], there is a whole big article on Reginald Bibby's work in Lethbridge, surveys of youth across the country and their substance habits and other risk-taking things. And the following issue has a whole bunch of letters to the editor from youth, and they

[11] Macleans is a Canadian weekly current affairs magazine www.macleans.ca/

are so interesting. Just reacting to some of the headlines and some of the ways the findings were portrayed in the issue of Maclean's. Just reading those letters to the editor gives you just kind of a sense of where some kids are coming from. Some of them are brilliant.

The reflective process assisted the group by creating a space where people could help each other understand the connections between evidence and practice.

Thank you for explaining the work that we do. (laughter) That was really helpful and that really -- it just really brought it down to a level that I could grasp. That's wonderful. Thank you for that.

- and it's just really important for people to learn from each other's experience and recognize that, not only does it [gender specific treatment] make sense sort of theoretically, but that you actually did notice very specific positive things, like better retention. Like, that is the -- you know -- the absolute, you know, crux of the issue that a lot of people are facing

Participants saw the benefit of reflective process and envisioned it as a way forth for others.

And I wonder how much do we have to -- and how do we inform the treatment providers, those who are in the system, to kind of examine -- you kind of have to examine your own life and your own beliefs, right? Of all of that, and that -- at least in our work with the women, that -- that seems to be kind of the foundational component. And you gave those examples as well, Deb, just with your group, you know, of it 'not being normal'

Often discussion took place on how the paradigms operating in the substance use field, particularly the disease model, do not serve women well and how public health and harm reduction oriented views, have some benefits towards moving us to a wider, more inclusive and possibly a more helpful approach for women.

She may be using the alcohol or smoking and, if she's a youth, she may be experimenting, as many do, but may not be in that -- on that continuum where she's abusing or has a problem with it. So I think there's a whole lot of education that needs to be done throughout the health care system, in terms of harm reduction and at least exploring that question, exploring that idea with women, so that lowering the stigma also works in that approach, in that harm reduction approach.

It's particularly important in alcohol . . . all the problems and costs are generated by the people in the middle of the bell curve. And those are all the injuries -- not just impaired driving, but falls, drownings, burns, all kinds of things -- and chronic disease, so cancer, osteoporosis, cardiovascular disease -- tons of stuff that we are just kind of beginning to wrap our heads around.

Mezirow identifies that transformations take place through elaborating existing frames of reference, learning new frames of reference, transforming points of view and transforming habits of mind (Mezirow 2009, p. 22). The data included here shows how the community was designed to create the conditions for this critical assessment of assumptions and exploration of options for action within new relationships. It also created the opportunity for another aspect of transformative processes, the recognition that one's perspective towards change is shared.

6.2.2 Critical synthesis, unruly practices and educated hope

Mezirow described systemic critical reflection as involving the understanding and challenging of dominant ideologies, that often leads to some form of collective or collaborative social action. Brookfield (2000) extends this thinking on systemic critical reflection to discuss the centrality of ideology critique in critical reflective processes, recognizing that in order to challenge ideology there is the need "to penetrate the givens of everyday reality to reveal the inequities and oppression that lurk beneath" (p 130). Giroux (2003) makes the connection between ideology critique and the need to help to equip learners with the "skills, capacities and knowledge they need not only to actually perform as autonomous social agents but also to believe that such struggles are worth taking up" (p. 96). Like the feminists concerned with political agency in democracies, critical theorists such as Giroux and Kincheloe (2008) see critical reflexivity about ideology as important, and as necessarily bridged to social agency and resistance. "Hope in this context does not ignore the worst dimensions of human suffering, exploitation and social relations; on the contrary, it acknowledges the need to sustain the 'capacity to see the worst and offer more than that for our consideration'" (Giroux 2003, p. 99). Giroux (2004) sees pedagogy as enabling understanding, action and resistance, and educators as having a responsibility as "provocateurs", in fostering critical synthesis and educated hope. Educated hope involves understanding current injustices and imagining alternative futures, as well as action to address both. In many conversations in the community a balancing of critique of current oppressive practices and alternative approaches which could be acted upon were discussed. For example, in the quote below I summarize the discussion in the webmeeting about harm reduction:

> *And it's really interesting to me because we've explicitly named that the interventions that they need to do need to fall into a framework of women-centred, as opposed to fetus-centred, harm-reduction oriented as opposed to abstinence-oriented, and collaborative as opposed to proscriptive. Right? That that's the frame we want to engage people on.*

Conscientization, which incorporates analysis and critique, and transformative action is an example of ideology critique as described by the transformational learning theorists (Choules 2007). Ideology critique also clearly maps onto feminist consciousness raising and feminist action research. Lykes and Coquillon (2007) see feminist and other forms of action research as "collective processes of inquiry that expose the ideological, political and social processes underlying and permeating systems of inequality" and "that seek solutions to everyday problems and to transform the social inequalities exposed through research" (p. 298). A format such as this learning community creates room for "critical reflexivity and 'just enough trust'" to enable engagement across differences, "creating in-between spaces for dialogue, appreciation, and contestation as well as alliances and solidarity" (Lykes & Moane 2009). The issue of action based on ideology critique is of interest to many: Fraser makes the link "throughout my adult life I have cared passionately about two things: the intellectual project of understanding the world and the political project of changing it" (Fraser & Naples 2004, p. 1106). Fien and Skoien discuss "action competence" as grounded in knowledge of root causes, knowledge of change strategies and visions of alternatives (Fien & Skoien 2002).

The community allowed for critique of the power underlying the medical model, how it resists even mild evidence-based interrogation, and how people have survived the critique and seen it as important. For example, I noted:

> *We published a book this past year on women's health . . . . And in this one section of it, where we talk about substance use and addiction, we also mention, you know, that there are pluses and minuses of using prescription drugs, such as benzodiazepines or painkillers or whatever. And it's really interesting to me that we got a huge reaction from some of the psychiatrists at the Centre for Addiction and Mental Health in Ontario around even having named that issue. We didn't say, you know, 'never take them' we just said, you know, 'they can be addictive and it's important to discuss with your doctor, whether you [need them], how long you need them for, and what you need them for,' and it was a basic harm reduction health message that we embedded in there, and got such strong, strong reaction.*

And I think that's one of our challenges, is that the medical model has really dominated in some ways approaches to most health issues, right? And so that you kind of have to have the individual diagnosis and learning plan rather than the sort of systemic, you know, possibilities for people to enter and engage in ways that they want, and that the very act of offering those systems is doing it in a way that actually addresses the root problems as opposed to, you know, individualizing them.

The moral approach to addiction was also raised and critiqued in how substance-using women who are mothers are highly stigmatized and marginalized; and are disciplined instead of helped as a part of "regulating" motherhood (Campbell, ND 1999; Greaves et al. 2002).

Yeah. And I think that [names participant] is right as well, that no one wants to talk about the third piece of that, that no one wants to talk about women of child-bearing years, mothers, in -- as the third stigma. (laughs)

And then the stigma, then that moral panic comes in, that there's something wrong with the woman morally, if she's using substances or alcohol, if she's drinking, when someone just mentioned, it may not actually be an addiction

The critical synthesis process in the community was spacious, safe and inclusive enough to make possible an examination of how, when looking for alternative approaches to addiction such as harm reduction, that we not continue to focus on individual change, rather than taking a systemic approach. This participant helps us critique progressive approaches as well:

I just want to go back to the discussion about social context and use, and social determinants of health for a moment. One of the things that I find interesting about the current context overall is that it is a neo-liberal context, which tends to really individualize social problems, and so there's kind of a framework or a filter through which sort of any kind of problem is shoved and so that it comes out at the other end as a -- as a, you know, personality issue or a mental health issue or whatever. And I -- you know, I think that there's a role for harm reduction, as we were talking about earlier, for challenging those kinds of very dominant ideas. But one of the concerns I always have, or one of the anxieties I always have about harm reduction discourses is their own tendency to focus on the individual and to incite healthy choices by the individual in a contextless way, so that what happens is people become responsible for their own health in new and interesting ways that result in more stigma and more blaming. So it's -- it's a -- always a caution I have about these kinds of discussions.

As well as critiquing the medicalized and individualized models, a discussion of alternatives was opened, in a way that accentuated the doable nature of approaches that

emerge from harm reduction oriented, women-centred, collaborative values, ethics, paradigms and praxis.

One participant mentioned the inherent potential of collaborative harm reduction approaches:

> *let's practice collaborative harm reduction. I mean, that's straightforward. I mean, for us to all think about, well, what -- what does that mean in our context? And, as you say, it doesn't have to be a full program, it can be, you know, done collaboratively with another service or as -- you know, we've talked about here, Krista talked about a women's centre sponsoring it . . .*

Another mentioned how harm reduction has generated a beneficial wider public discourse on substance use and addiction:

> *And I think that's the greatest gift that the harm reduction world has given us in some ways, is that it's forced a dialogue on the policy level and the public discourse, as Connie's studying, in ways that, you know, the addictions field never had before. We were really under the radar and there didn't used to be much in the news at all about us until, you know, until we started to be at this place of talking about harm reduction.*

I mentioned how important harm reducing approaches are to support any and all changes pregnant women may be able to make:

> *you know, it's just been such an interesting thing to reason through with them [those resisting a harm reduction view]. "Well, what -- you know -- what has been your experience, you know, with women when they come for help in pregnancy? How has the abstinence message gone over for the ones who are struggling with substance use issues?" And they said, "Well, it doesn't go over." And we say, "Well, exactly our point. So how do we break it down into a place where you are supporting her, wherever she's ready?"*

The community space allowed for people to think about 'relational' system change, that such change could start with questioning assumptions and approaches together with others in one's workplace – and how that was what had just been modelled in a presentation by a community member about developing and implementing girl-centred treatment. I noted:

> *You know, [names partipant], it reminds me of that article that we talked a little bit about last time, I think, that was written in relation to the -- the trauma field, but I think it applies to all of this work, for sure, is that one was entitled 'Relational System Change', because it seems to me in some ways that, you know, your work has been a bit about, you know, kind of helping people in kind of a motivational interviewing kind of a way, helping people look at their assumptions, you know, and listen to them, and say, you know, "Well, what about this or that?" inviting them to see more options than just the one that they're kind of attached to.*

In the focus group, following the community experience, one participant named the complex interlaced determinants of health facing women with substance use problems, and offered the following activist statement:

> *Yes, I was just going to say that I think that keeping the dialogue going is critical. I know for the population of women that we are working with they don't have services available to them, whether it's housing, whether it's a women's shelter, poverty is an issue, HIV, just their basic survival are all challenged and they don't have the special privileges that they need. So I'm so pleased that you've entered into this war and that you're bring us with you.*

In these ways critical synthesis, unruly questioning of current practices and educated hope were applied. The virtual community of inquiry successfully afforded space for reflection and critical synthesis, and in some ways achieved this through creating sanctuary for such resistive practice.

6.2.3 Eliciting validation and creating sanctuary

Transformative learning, as well as involving critical reflection and synthesis has also been described by Lange (2004) as having a restorative aspect. Where other transformative learning adherents have focused on the disequilibrium needed to disrupt habits of mind, she has described the opportunity for reconnecting with personal ethics at odds with competing cultural scripts implicit in workplaces and the dominant culture. Restoring these ethics to a guiding place in learners' lives provides the stability from which they can withstand the upheavals required to navigate a different life course. Hooks also describes how in community-based learning, there is a sense that there is a shared commitment to learning and "a common good that binds us" (hooks 1994, p.40). This acknowledgement of learning supporting the realization of ethical commitments can be foundational to ethical action in one's workplace or community. In this sense a community of practice or inquiry, and adult learning within it, can serve as an "ethical sanctuary" (Lange 2004, p. 130).

Taylor (2007) has described another affective aspect to transformative learning: validation as a form of support. In a virtual community of inquiry, connection and validation can help learners overcome alienating social relations they face beyond the community, such as isolation and disillusionment. In related learning forums, in which I

have participated, teacher/activists such as Joanna Macy have spoken of the importance of naming and acknowledging disillusionment and despair at the condition of the world, as a step in a process of taking action to change conditions that are larger than our individual circumstances and may seem overwhelming. Macy sees that voicing the despair in a group context helps us identify our collective resources and power and develop a sense of solidarity that enables action in the face of despair (NurrieStearns & Macy 2013).

Participants did voice despair and concern about how the demands of the day-to-day work in the field can be isolating:

> *So I'm a little worried about what's going to come, and when we fought so hard to get those things for women. And so I think this group and this dialogue will present a voice for all women, but I think hopefully a powerful voice, that we continue to at least maintain what we have and hopefully obtain more in the future. But I am very worried about where we're going.*

> [the community experience] *validates a whole lot in terms of what I think about Women's Services in terms of about the importance of connecting with others, and certainly heightened, if it could actually do that, and it did in many ways, heightened my interested to stay connected. However, going back to the day-to-day business of trying to help women on a daily basis and getting through the day with a high caseload prevented me from linking with others after this virtual community ended*

Participants also alluded to how sitting with grief and despair is often part of their daily work with clients. This is important as often grief has not been acknowledged as a key factor in addictions, rather it is been medicalized and treated through the lens of depression.

> *That is a big part of what we're doing in program, is grief, because we know -- and it may -- we know that the kids are coming in because of the background case histories we have, with multiple friends having committed suicide, with family separation as an issue. Oftentimes, you know, kids will have two or three suicides in their immediate family, just prior to entering treatment. So grief is a big part of what we work on.*

Participants also took strength from/ were inspired by the community of inquiry experience

> *I just want to say thanks, Nancy, and thanks to everyone. I think it's been really helpful and, if nothing else, just connecting with like-minded people once a month kind of uplifts my spirit and gives me a bit more energy.*

and also being able to hear from women across the country about programs that they're involved with in such an immediate and intimate way, where I can ask personal questions is really a helpful format for me.

As well as providing a space for the acknowledgement and expression of despair it also allowed for voicing pride in action taken

You know -- and I'll just caution you. It is brilliant (laughs) if I do say so myself but the one thing that has to be taken in consideration is the staffing patterns. You know, and we've had centres say to us, "We can't rotate gender" -- initially. "We can't rotate gender because we've got such a high male basis of staff" and there's other considerations with adolescent treatment, you know, in terms of staff ratios and things like that. So it is a -- it is a science to make it work with all the other legal requirements but it -- but it can absolutely work. It just may take time.

A sense of solidarity in an activist stance could be seen, in statements such as this summary one I made:

In some ways, I feel like that is a lot of this work, is to have the kind of, you know, people who are willing to walk that walk with others, of this -- not being afraid in that moment that, when you're being kind of questioned about your credibility or your, you know, facts or whatever, just really invite people to examine their assumptions rather than, you know, rather than losing it in that moment. And -- and it just strikes me that that is a lot of the work we have before us, is to do that same kind of thing that you weathered, you know, as people had to -- had all their reasons why -- why we can't or why we don't want to change.

It is important that a community which met for only five sessions (each session 75 minutes in duration) was able to create a climate for voicing despair and ethical concerns, for catalysing connections and inspiration. Field (2003) might see this as a form of "bridging social capital" where looser ties between participants as in this case have the potential to foster reflexive learning, as well as promoting the acquisition and development of reflexive practices, in part through being able to try on other perspectives across distance.

From early reading of steps in transformative learning (disorienting dilemma, self examination and critical assessment of assumptions, development of competence and self confidence in new roles and relationships), I was concerned that the community experience could not offer sufficient experience with disorientation to force shifts in perspective/ promote action. Later discourse on transformative learning includes discussion of shifts taking place over long periods of time, through intersubjective

experiences such as communities of practice, and through exposure to new roles and relationships and new social practices. An understanding and application of the conditions for perspective transformation from transformative learning theory added a proactive yet complementary element to the fostering of a community of practice concerned with evidence, analysis and action on gender in the substance use field.

Through space for critical reflection, for collective critical synthesis and for validation, the conditions were created for changes in "meaning perspectives" based in exploration of assumptions, increased awareness of the context of participants' beliefs and feelings, making meaning of experience, of reformulation of meaning, consistent with transformative learning theory and practice (Brookfield 2000; Hodge 2014; Mezirow 1991). In this way the specificity of in the transformative learning literature filled in gaps in the literature about cultivating communities of practice. With its avowed critical focus, the application of transformative learning approaches bridged directly to feminist pedagogical approaches. In the next section of this chapter the role of facilitation in fostering transformative learning is given some additional consideration.

6.3 Facilitation and Teaching

I had envisaged this community of practice or inquiry as a hybrid of feminist participatory action research and consciousness-raising brought to the online environment. I recognized in relation to feminist participatory action research that the community was not characterized by the traditional two-way, researcher-community relationship, and the participants were not marginalized in the manner that women with substance use problems are. I recognized that unlike consciousness raising groups, the focus of this community was balanced between examination of 'experience' and research, not focused largely on surfacing experiential evidence. I considered the choice points for quality action research mentioned by Bradbury and Reason (2003, p. 424) in terms of having a praxis of relational participation, but as the community took form, I realised it was not going to have the equality of participation that ideally characterize both FPAR and consciousness raising models. I had anticipated that it was going to entail my leadership to initiate the community and create the virtual infrastructure, but I

had expected that once the meetings had begun the participants would offer considerably more ideas for: topics to discuss, presenters who might support our learning, relevant readings and weblinks than was realized.

Minkler and Baden (2008) have noted how differences in time availability, resource access, knowledge and skill can affect participation in community-based research. Maguire (2008) identified that one of the most underrated limitations on participatory research is simply time. Indeed, participants while active discussants, did not step up to generate a significant amount of material. As such I found the role that I needed to play (beyond convening) in this community of inquiry included:

- scholarly practice to identify, assemble and do some preliminary synthesis of research on each topic related to women and substance use
- e-moderating skills (Palloff & Pratt 1999; Salmon, G 2000), to foster a dialogic context where ideology critique, ethical engagement, validation of perspectives and other elements of transformative learning could possibly unfold
- sharing my experience in sex- gender- and diversity-based analysis and translation of research-to-practice on girls, women and substance use issues - and to some degree modelling these skills
- acting as a boundary spanner, maven, or reticulist, who understands what the community participants know, makes linkages, bridges the points being made
- holding and fostering the hope that "conscious, action-oriented people especially those working and reasoning together can indeed achieve systematic and systemic change over time' (Bradbury & Reason 2003, p.235) on 'wicked' problems such as responding to girls' and women's substance use and addiction.

Holding hope can be seen in this encouraging comment I offered in the first session:

> *I guess that's my hope for this community, is to really think through, you know, how can we do this kind of more thoughtful approach? And it doesn't even have to cost more money, you know. Many of the best things that, you know -- like, the big study we'll look at next time, that SAMHSA did on making the system integrated on violence, mental health, and substance use issues. They didn't actually do anything new as much as they reorganized the way they did what they were -- you know, the way they were delivering care to women, to make it trauma-informed as well as have some trauma-specific aspects to it. And -- and to me that's our real challenge, is taking each institution or whatever, you know, kind of location you're at, whether you're working in government or -- or delivering service, to really think, you know, how do we -- how do we shift just,*

you know, a half-turn, even, to be able to do things differently that would make a very significant difference to women's access and women's recovery overall?

Kitson (2009a) has identified how heterogeneous groups need to be able to share different perspectives and consider what works and what matters for each; and in so doing, benefit from the roles of knowledge brokers and boundary spanners. Williams describes the boundary spanner role as in part reticulist (2002 p. 109), that is, involving consummate networking skills, including the cultivation of relationships, an understanding of the inter-dependencies among players as well as an appreciation of the structure of problems and their potential solutions. This is evidenced in the quote below, where I link up the collaborative work being done with women by one program for substance-using women, with the overall harm reduction paradigm operating in the substance use field, with the community's dialogic learning approach:

As to harm reduction and prevention and policy . . . the same as the women who come to the Enhanced Services for Women program - is that a lot of times what we need to do is come in like we are this morning and just talk about it. You know, that [names participant] had a chance to say, "You know, I don't get the definition of harm reduction," and other people can throw out their ideas . . . because to me, that's how we learn as well as how our clients learn, is kind of coming together and saying, "So what are you doing here and how do you see this?" Because then it helps me see what I might do in relation to it all.

Another example of the synthesizing and spanning role which was often required, is in the following comment I made that linked and showed appreciation for the comments of three participants. I built on and reinforced the concept of a continuum of substance use problems (use, problematic use, addiction), opened up the idea that this might be a useful concept to think about in terms of mental health concerns (mental health, mental ill health and mental illness) and at the same time proffered that women may be at any point on both these continua (not necessarily mentally ill when they have a substance use concern):

I think that frame, that you talked about earlier, too,[names participant, a policy analyst], about substance use, problem substance use, and addiction is a helpful frame, too, for people to get it, that not all substance use is addiction and requiring abstinence, by any means. That there's -- you know, there's a continuum. And I often use that same continuum, [names another participant, a researcher], around mental health and mental illness, too, talking about mental health, mental ill health and then mental illness, right? As a way of getting people to understand that problem that you, [names a third participant, a service provider], also raised, around everybody automatically assuming that

> *the moment you have a substance use problem, that you automatically are mentally ill as well, right? And just thinking about those continuua.*

Another aspect of the boundary spanner role is to display empathy and respect for others' values and perspectives while not meshing with all points of view, to create a safe enough space where people can air their ideas, listen to others and learn together a kind of balance between inclusion and separation. One participant in the follow-up focus group likened the experience to being in a small seminar class.

> *Well just to echo the rest Nancy, thanks so much for the opportunity. It was really unique for me to be a part of something like this and felt very welcome and felt like I was really getting, it was like I was back in school, but like in a small, small seminar class, you know like you get in grad school?*

Claiming and modelling the boundary spanner role appeared to help others assume it:

> *And also I think your reputation Nancy also is, you know, and other folks have mentioned, a real drawing card, but also is as like a ripple-out effect, so when I send materials that I think might be useful, and I say "Well, I'm participating in this research group and study cohort under Nancy Poole and they've prepared some powerpoints with her and her colleagues to present us" that's quite meaningful to other folks who again wouldn't have this necessary opportunity or chance to participate. So it really has that kind of rippling effect that I've appreciated.*

The leadership in synthesis and boundary spanning may result in uncertainty related to participants' understanding and application to praxis where "those involved cannot know exactly what we give away and how others interpret and use their knowledge" (Lindkvist 2005, p. 1204). At the same time the facilitation role is important as modelling of feminist practice, or supporting "learning aimed at social change" (Luhmann 2012, p. 67) with its potential to have ripples beyond the immediate community participants. In this sense, the *identification* with the leader or teacher who is modelling sex- gender- and diversity-based analysis, as well as having the chance to practice SGDBA within the community, and share the knowledge generated beyond the community, becomes as, if not more, influential on praxis as the feminist knowledge itself. The role of transformational leader or engaged scholar within the community takes on importance not as an aberration from equitable participation, but instead as leverage toward participant engagement in critical thinking and learning. This role of transformational leader or engaged scholar within a community of practice or inquiry was a theme in Chapter 5 where the findings were examined from a feminist lens,

emerged in this chapter where the findings were viewed from situated and transformational learning lenses, and will be taken up further in the next chapter in an examination of e-moderating and e-leadership.

Chapter 7 – Online learning in community

In this chapter, the potential of virtual communities as locations for knowledge sharing, knowledge synthesis and catalyzing of action will be discussed. First, what is known generally about the opportunities opened up by online learning mechanisms and processes will be considered. Then, how virtual communities can employ and extend the use of these online learning processes and will be described. How cognitive, social and teaching presences, as the underpinning of successful virtual learning were achieved in this study's virtual community will be illustrated. The argument will be made that virtual communities of inquiry (CoIs), which foster these presences are useful mechanisms for knowledge exchange in contexts such as this study, where critical thinking and action are needed to bring gender-related concerns forth from the margins of ever expanding academic and public discourses. E-leadership will be identified as an important extension of virtual teaching presence which is consistent with the work of the engaged scholar working in an online environment. E-leadership and other virtual mechanisms and practices needing further exploration for the enactment of feminist action research and knowledge translation more broadly in virtual environments will be identified.

7.1 Early recommendations related to technologically supported learning

When initially designing the virtual aspect of the community, there was relatively little written on the design and assessment of online learning communities. Palloff and Pratt (2001, p. 105) had provided guidance to teachers on technological options available and on teaching (and learning) in the cyber classroom, stressing that teaching online required certain qualities in the teacher/facilitator, and that online facilitation of learning was not a matter of directly transferring face-to-face didactic teaching methods and facilitation skills to the online classroom:

> *Another important consideration is the instructor's willingness to give up some control in the teaching and learning process in order to empower the learners and build a learning community. An instructor who is open to giving up control*

> *of the learning process, using collaborative learning techniques and ideas, allowing for personal interaction, and bringing in real-life experiences and examples, and who builds reflective practice into teaching, is a good candidate for teaching online.* (Palloff & Pratt 2001, p. 22).

Palloff and Pratt identified keys to success in 'electronic pedagogy'(p. 25) including: ensuring access to familiarity with technology, establishing guidelines and expectations, fostering participation, and promoting collaboration and reflection (2001). In the same time period, Salmon (2000) identified five comparable steps for effective e-moderating to provide/invite: access and motivation to participate in computer-mediated conferencing; space to socialize and network; opportunity to discover information; opportunity to collectively construct knowledge; and opportunity to develop critical thinking and "challenge the 'givens'" (ibid, p. 35). All of this guidance seemed entirely in line with feminist action research and transformative learning approaches.

As early as 1998, Bonk and Cunningham had linked the APA's fourteen learner-centred principles (grouped as cognitive and metacognitive factors, motivational and affective factors, developmental and social factors, and individual differences) in the light of technological developments to consider what "learner-centred technology" (p. 30) might look like. They saw tremendous, even superior, potential for collaborative educational technologies to support cognitive and metacognitive aspects of learning, and particularly for the motivational, developmental, social and diversity-related aspects. Bonk and Cunningham saw the use of electronic conferencing and collaboration in:

- placing tools in the hands of learners to "build, browse, link, draw, juxtapose, represent and summarize information" (p. 30)
- offering opportunity for novelty, curiosity, personal choice, control, effort and emotions
- creating social, interactional space that links distributed learners with common interests, so they can fill gaps in knowledge, widen perspectives, and encourage and inspire each other
- forcing learners to "consider variations between the way they view the world and those individuals from distinctly different social, economic, cultural and linguistic backgrounds" (p. 31)

They saw the need for creating situations wherein cognitive apprenticeship and dialogic possibilities of online collaborative tools could be fostered and examined.

Interest in online contexts for learning has continued. Alavi and Dufner (2005, p. 195) identified three categories of collaborative learning technologies: group support systems, collaboratories (electronic libraries, archives of data and systems to support retrieval of data) and integrated learning environments (instructional learning platforms). They see very significant benefits to the technologically supported learning, such as: allowing for globally scalable connectivity, more efficient interactions, as well as enhanced timeliness, range and depth of information afforded by virtual learning group members (p. 197). The authors stress that a fit among the pedagogy, facilitation of group processes and technology features is needed to achieve positive learning outcomes (p. 207).

Two themes which have been identified in earlier chapters also arise in the virtual learning literature: a) facilitation (in this case of virtual learning) and b) the role of collective community participation in online learning.

Facilitation - Palloff and Pratt (2001) offered a view of the interrelationship of student satisfaction, group collaboration, the technology used, the task/purpose/domain with which the group is concerned, and the facilitation. Of these elements of effective online groups, the discussion of the role of the facilitator was described most extensively, as involving:

> *comfort with the technology, competence with online facilitation, ability to communicate clearly and in a balanced way, comfort with a reasonable degree of chaos and conflict, creation of a safe container for the group, nurture of the development of relationships, promotion of self-organization and empowerment* (p. 139).

Salmon with her focus on e-moderating, created a table of competencies for e-moderators involving both knowledge and skills on one axis (understanding of the online process, technical skills, online communication skills, content expertise) as well as specific qualities to apply these skills on the other axis (Salmon, 2000, p. 40). The qualities she identified involve confidence in each of the skill areas, as well as constructive, developmental, facilitative, knowledge sharing and creative abilities to apply to each. She acknowledged how there are few people with all these abilities; and that empathy and flexibility were qualities with which to begin, as one learned through

training and experience the other competencies. Clearly researchers required to communicate research findings are not necessarily or automatically good candidates as e-moderators.

Community - Again in the context of technologically supported learning, the concept of 'community' is raised. Early online designers of web based learning communities such as Barab and colleagues noted that while on the one hand the term 'community' has appeal, on the other it is challenging to know how to design for 'community' and how to measure whether it has emerged (Barab 2003; Barab et al. 2001; Barab, MaKinster & Scheckler 2003). Barab identified how "designing for virtual communities involves balancing and leveraging complex dualities (participation/reification, designed/emergent, local/global, identification/negotiation, online/face-to-face, coherence/diversity)" (2003, p.199) which can be seen to be aligned with concepts raised in communities of practice literature and also with feminist concerns with the integration of diverse and global voices. A number of researchers considered how facets of social capital such as trust, reciprocity, identification and shared vision were linked to knowledge sharing in virtual communities (Chapman, Ramondt & Smiley 2005; Chiu, Hsu & Wang 2006; Daniel, Schwier & McCalla 2003; O'Neill 2004; Yuan, Gay & Hembrooke 2006). By 2009, Akyol, Garrison and Oden (2009) were noting an increasing emphasis on building learning communities in order to foster learning in online and blended learning environments, and how a sense of community was particularly powerful for participation in such learning environments.

7.2 Virtual engagement and participation

The study required consideration of what is different about participation in an online context, or what aspects of *online* engagement and participation require attention. There was surprisingly little guidance in the literature.

Some literature was found about women's participation online, and a possible digital divide, but this seemed to be more about exclusion of access, than about ability or interest in virtual participation by women. As early as 1995, in *Nattering on the Net: Women, Power and Cyberspace*, Australian feminist Dale Spender had identified how power and exclusion were operating in gendered ways in cyberspace, and at the same

time the strong potential for women's involvement in virtual connectivity and action (Spender 1996). While some feminists have expressed concerns about what is lost in online communication, others have embraced the potential of virtual social and political networking, to the point where Spanish feminists have coined the term "social cyberfeminism" (Puente & Jimenez 2009). Some gender differences in online participation in online courses (versus online communities or activist networking) continue to be documented: and these differences have been found to vary across platforms (social media versus other forms of Web2.0 applications) (Huang, Hood & Yoo 2013); vary in approaches to e-mentoring (Rockwell, Leck & Elliott 2013); be related to satisfaction with learning (Nistor 2013; Rovai & Baker 2005); and be mediated by age (Chyung 2007). None of these differences related to online courses seem relevant in this case, with the exception of the approach of women mentors, such as was partially my role in this study.

Clearly the most significant aspect to online participation is that it is distributed. Reeves and Reeves (2008, p. 46) state that most noteworthy online teaching and learning initiatives have been driven by the goal of providing "greater access to educational opportunities for those who are disenfranchised by distance or temporal constraints" and also by the desire to enhance the quality of teaching and learning. Participation in virtual learning communities can link and involve people in information sharing, synthesis of evidence and discussion of options for action, when travel time and funding for face-to-face meetings are not feasible. Such virtual participation can also be seen, not as in lieu of, or a poor second to face-to-face meetings, but as beneficial and enabling linkages that would not be imagined or possible in a face-to-face environment. In online learning contexts such as the one involved in this study, this is particularly true. The virtual context was ideal for creating visibility for, and pan-Canadian involvement in, a marginalized or denigrated topic, such as bringing sex- gender and diversity-based analysis and action to the substance field.

One participant comments on the opportunity the virtual context supplied.

> *It's a new avenue for learning - the web-base sort of work - as I think is just noted, it's going to be more important for a lot of us, given the physical restraints and tightening up on opportunities that we might have had in the past, to meet face-to-face. So for me, it allows me to sit at my desk but still really feel like I can be a part of a rather rich discussion.*

A second aspect to participation in an online learning community is that participation is disembodied. In the web meetings involved in this study, we could have turned on our computer cameras to be seen while we were talking, but I chose not to invite this level of interaction. We could also - as I have advocated when a team of people are presenting in a single webinar - posted our photos (in this case in the accompanying web workspace) to flesh out the experience of each other. However I chose to use the disembodied space of the web meetings as an asset that did not need mediating. The virtual discussion then centred not on how people looked, but on the evidence and the discussion questions being displayed on the screen. In this way, what was lost in having visual cues was made up for through keeping a focus on our shared purpose and vision. In a swift community with knowledge translation goals such as this, I wanted to test the role of a common purpose, over social capital, as the glue. As one participant commented:

> *I think this experience heightens my sensitivity to the capacity of technology to move an agenda.*

Again this was not only a deficit position from face-to-face relational and sustained engagement, it also had specific, participation leveling benefits. The virtual environment serves to de-emphasize age, race and class differences made evident through appearance, and to bring the focus to what participants are saying - and importantly, choosing not to say - about how their location affects their perspective. Thus this disembodiment can serve as an effective leveller. Where there is inter-cultural and multisectoral involvement this can offer a significant benefit. An example where this engagement and leveling was made possible in a related virtual community, involved the respectful web exchange on women's treatment needs engaged in by: a senior civil servant responsible for drug policy for the government of Canada; a group of active illicit drug users of Aboriginal descent from the Downtown Eastside of Vancouver (signing in from the inner city campus of Simon Fraser University near the Vancouver Area Network of Drug Users office (http://www.vandu.org/); and researchers and treatment providers wishing to study and deliver trauma-informed substance use support within prisons for women. The distance, leveling, and safety afforded by the virtual meeting was important for these participants to be willing to engage with, and to hear each other.

It can be seen that such virtual participation requires motivation and efficacy, as well as facilitation to support mutual engagement. Motivation with its link to self leadership has been looked at to some degree in relation to virtuality. Andressen and colleagues (Andressen, Konradt & Neck 2012) have found that self-leadership has a higher influence on motivation in virtual work structures compared with co-located work ones. Indeed, the challenge for involvement in virtual knowledge translation and virtual communities - beyond the challenges of distributed or disembodied participation - is that they require significant commitment on the part of the participant to initially engage. The topic and the clarity of expectations leading into the community become as critical as the modelling and guidance for participation once engaged. As was seen in Chapter 4, people mentioned a number of motivations for attending including the trust in my knowledge base as convenor of the sessions, the content to be discussed, and out of interest in the virtual context itself.

> *So I come with sort of two hats as far as prevention and clinical piece. But also just wanting to explore this type of community of practice.*

Reeves and Reeves (2008) discuss the how participation in virtual communities involves metacognition, which they describe as "a learner's ability to 'think about thinking, to be consciously aware of oneself as a problem solver, and to monitor and control one's mental processing" (p. 47). I agree with their view that "the Web is a uniquely powerful vehicle for implementing these dimensions" (p. 47). The distance created by desktop videoconferencing, where participants have the opportunity to be privately assessing the quality of the material presented, to be simultaneously looking up material that is triggered by other participants' points, to be following up on points with speakers privately or publicly in the chat function, as well as joining the overall discussion verbally, certainly has the potential to potentiate metacognition and learning. This strength of the online environment, specifically for prompting the processing of material that is dissonant from participants' current thinking, values and attitudes may not be obvious. Participants in online communities often engage me after a web meeting, to express how startled they were by a point made in a web meeting, and how they were glad they were not in a face-to-face situation as their body language would have conveyed their disbelief, ("I might have fallen off my chair"). Their invisibility in the moment, and the time to think about what was said, provides the opportunity for

individual questioning of assumptions and view, and prevents disrespectful communication.

As mentioned above in the discussion of early developments in the field on online learning, the issue of trust continues to be discussed as a factor in the online context. Sharrat and Usoro (2003) applied a three part model of trust - involving integrity-based, benevolence-based and competence-based trust - to the online environment. They saw that integrity-based trust was important as a basis for knowledge sharing; and was characterized at the community level by a community "upholding trustworthy values such as mutual reciprocity, honesty, reliability and commitment" (Sharratt & Usoro 2003, p. 190). They also later identified how all three forms of trust are "empirically inseparable" and "buttress each other" (Usoro et al. 2007, p. 1); and in particular how people's passion for knowledge and view of the community as competent (competency based trust) was linked to integrity-based trust. Danish researcher Gerdes (2010) notes how trust is a common characteristic of all human existence, important to on- and offline collaboration, and how the voluntary nature of the community and its inquiry-based goals may serve well to support trustful collaboration in the online environment.

Trust is also engendered in a context of respect for diversity of perspectives and for risk taking. A critical goal of online participation in this case was to be emancipatory, to encourage participation in ways that supported thinking outside the box and freely arrived at directions for change. As Tomscik found in studying participation and gender in Second Life, collaborative learning is maximized when the virtual environment supports a shared purpose, sense of respect, and connection among members (Tomcsik 2010). The collective purpose in improving the response to women by the substance use field, as well as the respect for the varied locations from which people were working, became key to the development of trust and participation in this short term community, over any strong sense of community that a longer term involvement might have achieved over the long term.

7.3 The challenge: bridging the virtual environment with participation, learning and action

The virtual community designed and implemented in this study involved bridging concepts, mechanisms and promising practices arising from:

- virtual communities of practice
- online learning approaches, particularly those identified in virtual communities of inquiry
- knowledge translation projects involving virtual mechanisms
- consciousness raising/feminist action research

The interest in this study was in whether and how elements could be linked and supported by technology in a way that promotes online learning and gender-based analysis as well as practice/policy-based action. Would people working on addictions issues in Canada be attracted to such a forum, to discuss and perhaps be challenged by evidence about the gendered nature of addiction and the need for gender-based approaches to prevention and treatment? Could a short term online context support the examination and critique of evidence in a 'safe' way? Might such engagement catalyse action, be transformational and liberatory in the sense envisaged by action researchers and critical theorists (Kincheloe, McLaren & Steinberg 2011; Lykes & Coquillon 2007; Lykes & Mallona 2008)?

Torraco (2002) discusses the work of Wenger and other learning theorists in the context of new technologies. He discusses how distancing technologies require people to “possess the capabilities for inference, imagination and mental modeling to understand what is going on elsewhere” (p. 456). Wenger’s framework for social learning - one that involves shared practice, recognition of competence in community, formation/shifts in identity and meaning making - has relevance in understanding learning in the online environment. Participation in virtual communities of practice involves engagement in social practice and access to collective knowledge that can support mastery of virtual technology itself. The online environment becomes an authentic setting for participation, practice and development of competence, in and through, relationships with others in the online environment.

Research on what is working in the online context related to virtual communities and virtual learning was drawn upon. This chapter will explore what was utilized from this research. It is important to note that while direction was drawn from the larger literature, this study describes and analyses a unique form of virtual community:

- not as long term, or a tangibly practice-based as any of the virtual communities of practice reported on in the literature
- not blended (with both face-to-face and online supported learning), nor delivered in an completely asynchronous online format, as many other studied communities of inquiry
- not as structured and academic as a post secondary online course, nor as unstructured and non-academic as an online chat or blogging group
- with the hybrid aims of "translating knowledge", "raising consciousness" and promoting action on gender and addiction issues.

The length, virtual location, scope, multi-sectoral participants and hybrid goals of the community were deliberately chosen. As a location for knowledge translation on gender and substance use, the virtual intervention needed to: fit the context of the busy addictions professional in the time commitment to be volunteered; be credible in that it was centred on evidence; and offer the conditions for transformative learning and application to practice to promote action to address the inaction on gender in dominant addictions practice and policy. In addition it need to be easy to navigate and accessible through government and hospital firewalls.

The community design draws from both community of practice and community of inquiry approaches. Initially the literature on communities of inquiry described the constructivist approach to supporting learning in more formal educational settings, and placing focus on facilitating cognitive presence. As such the less formal, situated learning model on which communities of practice are based seemed more applicable to the design of a voluntary, short term location for knowledge translation. However as I realized the extent of facilitation required to support transformative learning, I found it useful to draw more upon the constructivist learning methods outlined in the CoI literature. In recent CoI literature, attention is brought to "learner presence" (Shea & Bidjerano, 2012), foregrounding learners as collaborative knowledge builders, which

links to the concepts of participant characteristics, participation, motivation, and identity formation inherent in the CoP model.

The accessible virtual nature of the community which used various mechanisms to support learning was appreciated by those who participated:

> *So you know, how I came into this initially was just mostly from my job at the time, which was about, you know, writing, developing learning content for addiction staff . . . . The other part that was a big seller for me was . . . the web-based kind of technology, one because it's something I'm absolutely fascinated with, and in my current role I am very much in the infrastructure part of developing e-learning, so that really backend technology piece of it, but I always like to stay very current in terms of being up front end and that end user, that one who, you know, uses the tools that I'm trying to create, and so it's always good to keep my finger involved in that and be able to experience technology in a way that's accessible and user friendly and very much [names another participant], like what you're saying, is that piece of being able to have multiple ways of learning simultaneously, you know, I do – I'm not a great – by sitting in my chair listening, and I've been engaged in part of that.*

The following section describes how this was achieved through deliberate application of the community of inquiry model.

7.4 The Community of Inquiry framework

The community of inquiry (CoI) framework developed by Garrison and colleagues (2003) was appealing to support the design of a learning community in that it describes a three part foundation underpinning teaching and learning in the online environment which can be utilized to consciously design a virtual learning community. Garrison and colleagues developed this framework to support teaching in blended (face-to-face and asynchronous online) contexts for learning by higher education students, yet it proved helpful in the design of this monthly synchronous (webmeeting) learning context, which was supplemented as the participants wished, with asynchronous communication and online research.

The CoI framework is comprised of three interdependent and interactive elements: social presence, cognitive presence, and teaching presence (Garrison & Anderson 2003). Learning is seen by the authors to occur within the community through the interaction of these three core elements. In communities of inquiry, people construct

meaning through epistemic engagement, as learners, teachers and social connectors (Shea & Bidjerano 2009). Creating and sustaining a community of learners in an online learning environment (Akyol & Garrison 2008) becomes an important goal.

Figure 7.1 Community of Inquiry Framework



Source: Garrison RD & Arbaugh JB (2007), p. 158

7.4.1 Virtual support of social presence

At the time of building the community related to this study, Garrison had defined social presence as "the ability of learners to project themselves socially and affectively into a community of inquiry" (Garrison, Anderson & Archer 2009). More recently he has defined social presence as "the ability of participants to identify with the community (e.g., course of study), communicate purposefully in a trusting environment, and develop inter-personal relationships by way of projecting their individual personalities" (p. 352). Virtual social presence is visible as open communication, within an environment where it is comfortable to share ideas, to express views and to collaborate.

Garrison and other researchers interested in technologically supported learning often describe social presence as a means to greater cognitive presence. For example Vaughan and colleagues (Vaughan, Cleveland-Innes & Garrison 2013, p. 25) note: "The focus of social presence is to support the affect, communication, interpersonal connections, and cohesion that support the inquiry process and deep approaches to

learning required for cognitive presence". Yet from the lens of feminist consciousness raising, the fostering of social presence can be been seen as an important foundation in and of itself, to achieve aims of connection, visibility and validation of voice. For example Merrill (2005, p. 48), sees that "Education is often a space which enables women, both individually and collectively to take stock of their lives and reflect on their identity/ies – a biographical reflection – developing and creating a transformatory life project". Regardless, social presence "plays a critical role in creating an atmosphere of safety and trust for learning in community" (Akyol & Garrison 2008, p. 17).

Vaughan and colleagues (2013) discuss planning to design a climate that will support open communication and cohesion. Social presence has been identified in research transcripts by coding for "affective expression, open communication and group cohesion" (Akyol & Garrison 2008, p. 7). For example, use of vocatives, inclusive pronouns such as "we," "our," and "us," have been seen as indicators (Akyol, Garrison & Ozden 2009, p. 76). It has been speculated that in face-to-face and blended communities social presence may be achieved more readily; and in online communities trust and group identity may be more likely to build over time. In the webmeeting context, which can be seen to be on the continuum between face-to-face (synchronous) and web-based (asynchronous) contexts, it appeared that the format of each webmeeting session created enough safety for expression of emotions and views about the topics, expression of affirmation of each other's thinking/practice and some discussion of shared beliefs and movement toward collaboration. Throughout this thesis the included quotations of participants have illustrated how personal stories, humour and other connective expression were achieved through such slim connectivity[12]. However when asked about their experience of the virtual environment directly in the focus group eight months post community, some participants did express the wish for more support of social presence or length of time for it to develop:

> *Yeah, I would second that in that you know my experience in other kinds of blended experiences have been that generally there is that sort of cohort face-to-face meeting first and it does and from my experience increase participation in subsequent meetings.*
>
> *I really very much appreciated the diversity of the folks that participated in this. I think for me possibly the challenge, I don't know if challenge is even the right*

[12] In each webmeeting short introductions and updates were done by participants, followed by presentation and discussion of academic or clinical practice evidence, followed by discussion and reflection on the strengths of the material presented and its application to practice and policy.

word, but regarding the question of a sense of community to develop, I suspect for me we would have needed to do this a bit more frequently

but that part about building cohesion in the initial part is really important and so the fact that you on this particular format, Nancy, had areas where we, you know, we had a homepage or a webworkspace that we could go to and share information, that was a good idea.

A number of researchers have discussed the need for understanding how to foster social presence, trust and/or community in the online context, in the service of transformative learning. Ryman and colleagues (Ryman et al. 2009) underline the importance of social presence in making possible the type of exchange that leads to innovative solutions to increasingly complex problems, for participants to see their practice in new ways. Swan and Shea (2005) recommend facilitators seek ways to evoke personal experience in discussion and this indeed was a tool often used in this community. The challenge is to maintain a balance between expression of individual experience and linkage to examination of other forms of evidence, and reflection on its relationship to multiple levels of social context.

Aragon (2003) discusses the strategies of providing frequent feedback, promoting the sharing of personal stories and experiences, and using humour as elements of creating social presence in online environments. Immediate feedback and eliciting of experience were often evoked, often with an element of humour (however self deprecating). The following exchange in the focus group between myself and one of the participants, is illustrative of such interactive processes which took place throughout the community meetings:

NP: Hmm. D, do you want to weigh in on this one?
D: No, I don't think so.
NP: Okay.
D: It certainly heightens my sensitivity but it hasn't done anything – I haven't had the opportunity to bring learning into practice. I'm just waiting for an opportunity; how about that?
NP: (laughs)
D: It's just that there's the stuff that you and I are trying to do around FASD and so on. It fits in that category.
NP: Yeah, I think that does relate. I guess that's what I was kind of interested in, and for those of you who don't know, D and I have been doing a fair bit of work around trying to think about how you fit the issue of prevention of FASD into larger alcohol policy strategies. . . So we've mostly, at this point only raised the questions at various points, we haven't actually been able to shift

anything yet, but you know I think even raising the question is a form of action in lots of ways.

D: Oh, absolutely, particularly on this issue.

Given the voluntary and informal nature of the community, tasks were not assigned for people to do together to support collaboration (as might happen in an online course); and given the short term nature of community, sustained interdependence or group development was not a goal. A balance was needed between supporting sufficient social presence to evoke dialogue, without involving so much social interaction that it would not constitute a rigorous enough approach to the topics. A balance between introducing and supporting expression of varied points of view, without evoking unproductive conflict was also needed. In this case I tried to use the presentation and collective examination of various forms of evidence as the lever, to evoke the sharing of assumptions, and the examining of how one's assumptions and others' assumptions fit with the evidence. Setting a tone of curiosity about the types of evidence-based practice in the addictions field, and on what assumptions they are founded, served to evoke sharing of ideas, assumptions and examples from participants' lived experience. As such, social presence was created through design and leadership, requiring more than creating the opportunity to interact. In such a context, the recognition and validation that others have a common interest and purpose in exploring complex issues - gendered approaches to health promotion, policy, harm reduction and treatment - creates cohesion and space for sharing about one's own practice and for enacting critical thinking. Ryman and colleagues (2009) see dialogue as most important for communal inquiry, as it not only facilitates knowledge generation but also makes room for exploration of shared beliefs and values. It is critical that discussion is done from a location of safety and shared sense of purpose. As Leimeister and colleagues (Leimeister, Ebner & Krcmar 2005) have noted, the sense of shared purpose, and good intention in exploring complex, contested territory together with the shared goal of improved practice/policy in the field creates a "perceived goodwill" (p. 102) leading to trust.

The concept of social presence links to Hemmings (2012) concern with "affective solidarity" as necessary for a sustainable politics of feminist solidarity. While learning theorists may focus on social presence as a condition for learning, feminists interested in social change might argue for a more serious account of intersubjectivity

and relationality in the online environment, as a condition for knowing and transforming ourselves and the world – a link between the ontological and the epistemic. Hemmings cites Probyn on the importance of reflection on the lack of fit between our own sense of being, and the world's judgements upon us. In a vCoI one can connect, undertake feminist analysis, including disrupting external disparagement of feminist goals. In the vCoI developed, this form of communal feminist activity (reflective disruption) was priorized as a form of social connection and presence, over the development of identity or sense of belonging. The recognition of each other, the common feeling of the undervaluing of women with substance use concerns and of us as participant researchers, service providers and policy analysts interested in women's substance use, and the lack of fit between the evidence on women's health, service delivery and policy structures can "produce a politicised impetus for change" (Hemmings 2012, p. 150). Feelings of dissonance and solidarity are important as underpinnings of a collective endeavour that challenges existing values and generates alternative ones, that is, a collective endeavour that extends beyond being a collective intellectual exercise.

Hemmings discusses how important is "knowing differently, as well as knowing different things or knowing difference" (p. 151). This process of engagement with others across difference (and distance) in a dialogic process in addition to, as well as through, examining evidence becomes important. Relationality and intersubjectivity are thus affectively as well as abstractly conceived, and are intimately related to care and empathy,

> *challenging the status of the expert, considering the importance of shared epistemic claims from below, thinking outside one's own initial investment in the desire for clearer and more accountable knowledge; these are all the features of an affectively attentive epistemology that allows for transformation of all participants in the research field as well as knowledge itself.* (Hemmings 2012, p. 151)

Researchers have noted relationships between social presence and satisfaction with the community of inquiry experience, and well as between cognitive and teaching presence and perceived learning. It appears that satisfaction, learning, and action, and the three CoI presences are inter-related and multidirectional (Akyol, Garrison & Ozden 2009).

7.4.2 Virtual support of cognitive presence

Cognitive presence is the extent to which the participants in a community of inquiry are able to construct meaning through sustained communication (Garrison & Vaughan 2007). Fostering critical discourse and reflection is central to cognitive presence. Formal assessment of the nature and quality of critical discourse and thinking was not possible in this voluntary context. It can however be seen through some excerpts of the exchange in webmeetings. For example the following quotes demonstrate how participants from various settings connected the evidence about trauma-informed practice to their practice, in response to questions presented onscreen to foster reflection and dialogue:

> *I was just looking at the two questions there and a couple of things kind of popped into my head as to why we have not attended to the intersection between trauma, violence, and substance abuse and I think part of that comes from . . . not having gender-specific substance use intervention and so not really seeing a need to include trauma-informed practice. And I think that we've shifted. And certainly, here in [names province], with the creation of my position, which is focusing on women's health issues, women's substance issues, I think we're really in a good place now to be able to weave or braid some of those pieces together and develop the women-specific substance use interventions that's very trauma-informed, and that encompasses mental health concerns and the whole list of women's health issues that have been left out of interventions in the past.*

> *Thank you very much for just a wonderful presentation. I certainly agree with the last speaker and I think I'd also like to add to that what we're experiencing with our women [in a correctional setting] is the minimalization that was talked about in the presentation, that many of these women think their lives of abuse and trauma are normal so they don't even know enough to identify it. A couple of the things I'd like to make mention of is the tremendous need for sexual health education . . .*

After considerable conversation about the application of trauma-informed practice in both correctional and community settings, tied to readiness-to-change, and readiness to access treatment, I added:

> *And that in some ways, being trauma-informed in a correctional centre is perhaps respecting that pacing more than ever, and just figuring out a way of talking about change without having to make it be as big a therapeutic change perhaps, but a more pragmatic change that could be like learning coping strategies or whatever, that could be quite practically applied within the context of a correctional system and much more of a link with community-based services like Seeking Safety groups and whatever, being made. Really honouring the women, that pacing is an extremely important part.*

I made considerable use of probing questions as well as comments (such as the summary one above) to cultivate movement past exploration, to integration and possible application in their practice. In both face-to-face contexts and in webmeetings I have used probing questions such as "what do you make of the evidence presented about . . ." as well as summative comments such as the one above about pacing. In both face-to-face and online contexts, participants have mentioned that the making and repeating (as above) of summary comments stimulates their integrative thinking and prompts application to practice. They report that even more than probing questions, summary comments "stick" with them, keep them thinking, and come to mind when they are in a "practice moment". This is the value of the dialogic space, unlike a solitary web browsing or reading, where the connecting of ideas and multiple possible applications to praxis can be raised, weighed and summarized.

Garrison and colleagues (Garrison, Anderson & Archer 2009) recommend the practical approach of looking for evidence of the sequence of the process of critical thinking when considering cognitive presence: that is, looking for a triggering event, for exploration, integration and resolution. Indicators of the first three steps of such a progression of steps include (but are not limited to): presenting background information that culminates in a question, asking questions, offering comments that take a discussion in a new direction, making suggestions for consideration, building on other's ideas, connecting ideas, proposing solutions (ibid.). Evidence for all these indicators for the community as a whole can be seen in the participant quotes, however given to the fluid nature of participation in the community, the coding of utterances by any one participant for the integration of ideas and the construction of meaning was not possible.

The participants did a significant amount of questioning of each other and synthesizing for and with each other.

> *That is so interesting to hear, you know, just how much wholism you have been able to build in with all of those different topics and . . . to focus on the woman's health as well as her parenting, I think, is a really neat linkage there.*

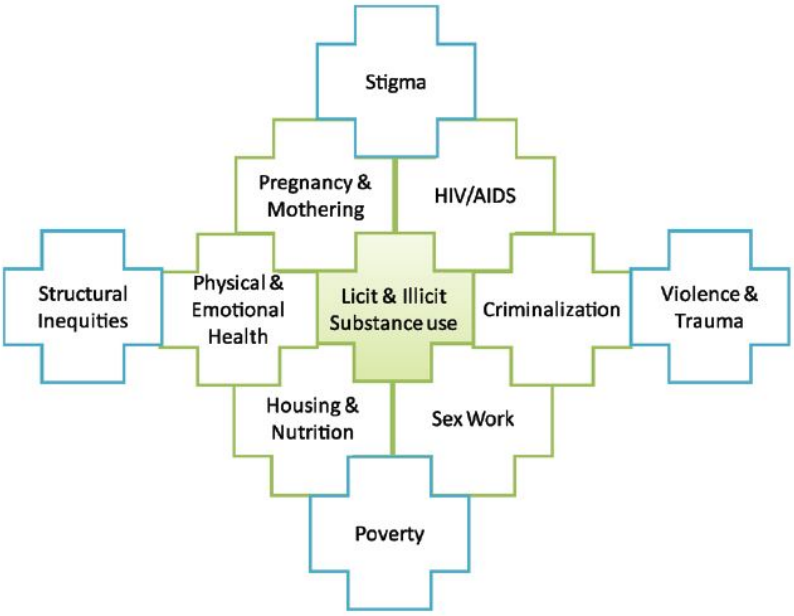
As such, critical thinking is both a process and product of the community. The online environment is exceptional in its potential for the extending the opportunity for critical thinking and learning to a widening circle of those in a position to apply to practice. When asked if they had returned to the community's web workspace or the

public website (www.coalescing-vc.org) for links or documents such as the discussion guides (derived from the community presentations and discussion), one respondent said:

> *yeah, I've gone back there and actually have found it a really useful tool to pull off and circulate to colleagues, because there'll be bits and pieces of course that have, you know, less or more relevance directly to me and my work, but because of the network that we have I'm, you know, able to direct some of this new and emerging pieces to folks that are directly working in the field, and so I've found it just phenomenal as an opportunity for that.*

Much more systematic analysis of the enactment of critical thinking and discourse can be done in text based virtual communities, and in extended courses. In this case, the Discussion Guides (See Appendix 3) which are built from the presentations and discussions in the virtual community serve to document the practice and policy examples brought forward. Further the guides provide a view of how participants saw current gender-informed practice being enacted; were able to make connections among types of practice which might utilize gender-informed approaches; and saw potential application of feminist intersectional approaches. On the topic of trauma-informed approaches, participants were able to identify how the centrality of women's experience of trauma could be integrated in the five tiers of treatment/support identified in the national treatment strategy (See Poole & Urquhart 2009, pp. 5-7). On the topic of harm reduction approaches, where less gender-informed practice is in place, the discussion was more theoretical, as how gender and other determinants of health might be seen as legitimate territory of harm reduction practice, since harm reduction practice to date had been centred on (gender blind) substance-specific harm reducing interventions such as establishment of mechanisms for needle exchange and safe(r) injection sites. The image (see Figure 7-2) in the discussion guide on *Women-Centred Harm Reduction* (Poole, Urquhart & Talbot 2010, p. 3) is a visual representation of the critical thinking on gender-informed harm reduction which took place in the vCoI, demonstrating how the discussion generated ideas for taking harm reduction in new directions, connecting women's health needs and realities, health promotion and, proposing solutions.

Figure 7.2 Visual representation of the community's thinking about gender-informed harm reduction



As such the discussions in the vCoI – and particularly on the topic of women-centred harm reduction - were able to evoke critical thinking in and through online dialogue, in a way consistent with Walters and Manicom's definition of radical adult feminist education:

> *It is a participatory, democratic, non-hierarchical pedagogy which encourages creative thinking that breaks through embedded formats of learning. It valorises local knowledge, working collectively towards producing knowledge, the principle of starting from where people are situated, and working to develop a broader understanding of structures and how these can be transformed. It strives to foster both personal and social empowerment …(it) must … engage with the ways in which the social categories of race, ethnicity, culture, age, social class, sexuality and physical ability are implicated in the constructions of gender* (Walters & Manicom 1996, p. 7).

One aspect of cognitive presence in an online community setting is evidence of collaborative knowledge generation and/or knowledge synthesis that leads to innovation, beyond simple information exchange. In a study of vCoPs in three multinational organizations in the IT sector (Correia, Paulos & Mesquita 2009), members in commercially-based vCoPs identified that such participation allowed them to disseminate their knowledge in a way that could be seen and recognized widely, which they saw as beneficial to learning and professional development. However they

also noted that time and other constraints did not make it possible to be involved in collective or collaborative knowledge creation, beyond the obtaining and sharing of information. In contrast, the virtual community involved in this study afforded the opportunity for knowledge about women's substance use to be made visible and to be collectively synthesized, linked in new ways, and applied to a range of new and different settings.

7.4.3 Virtual teaching presence, facilitation and e-leadership

Vaughan and colleagues (2013) define teaching presence as "the effort and activity around the design, facilitation and direction of cognitive and social processes in learning communities for the purpose of realizing personally meaningful and educationally worthwhile learning" (p. 46) They stress the (pro)activity involved in designing, facilitating and directing the educational experience, and mark how this differs from the role of "sage on the stage or guide on the side". They also underline how they have used the word teach*ing*, not teacher, presence (p. 14) to indicate how all participants in a collaborative learning environment can assume teaching responsibilities depending on the context. As the early thinkers about virtual spaces noted, just creating the space for interactivity does not ensure learning and engagement.

Vaughan and colleagues offer numerous principles of practice (p. 17) when creating and sustaining purposeful communities of inquiry. The first two principles listed below relate to designing the virtual learning context, the second two relate to facilitating the collective learning and the final two are concerned with the ongoing directing of an educational experience.

1. Plan for the creation of open communication and trust
2. Plan for critical reflection and discourse
3. Establish community and cohesion
4. Establish inquiry dynamics
5. Sustain respect and responsibility
6. Sustain inquiry that moves to resolution

Communities of inquiry, especially those with links to feminist consciousness raising principles, need both the facilitator and the participants "to engage, interact and

contribute to learning in new ways" (Vaughan, Cleveland-Innes & Garrison 2013, p. 14). The facilitation needs to be flexible, encouraging direction and leadership by participants, and at the same time providing an effective learning experience. In essence the facilitator of the CoI needs to provide: support for participants to fulfill their optimal role in contributing to their own and others learning; as well as active guidance to evoke reflection and discourse; and more direct guidance to the inquiry. The direct guidance in this community took the form of identifying presenters (from within in the community and beyond), suggesting literature, resources and programs to be explored, as well as focussing and summarizing the discussion. The community afforded me the opportunity to experience firsthand the many dimensions to teaching presence in the virtual context.

In early feminist consciousness raising groups (as I thought I was recreating in the online environment), there was eagerness to share experiences and theorize from this experience. Contributions by all participants seemed equal, as we all had legitimate experience to bring to the engagement in collective theorizing. This too is the underlying assumption of community based research, that all participants have the potential to participate equally, and participant experience will form the foundation of the research. However in this online community of inquiry, while all participants had relevant experience, and all had the potential for engaging in discourse and reflexivity, they did not seize the opportunity to organize the learning experience, instead indicated interest in being guided in the exploration of gender and addiction issues. As Vaughan and colleagues summarize:

> *Collaborative communities emerge, and are sustained, through shared purpose, joint activity, and interaction. These commonalities must be identified, illuminated, and fostered through the leadership of the teacher to facilitate these aspects of the community. It is through facilitation that social presence emerges and cognitive presence evolves.* (Vaughan, Cleveland-Innes & Garrison 2013, p. 61)

I realized early on that indeed I was not going to be able to play the more equalized, participatory role of 'guide on the side'. In coming to understand my leadership role in the virtual context, and the potential role of other scholars interested in virtual knowledge translation, I looked at my work as facilitator of this CoI in the light of the literature on online facilitation of transformative learning, and e-leadership of virtual teams.

Gurr (2004) discusses how there are significant differences in leading in technology-mediated environments. He sees that in research on virtual communities, often attention is brought to the community process at the expense of exploration of the leadership involved in the development of the learning community. Characteristic of leadership in virtual environments is a greater emphasis on the ability of leaders to communicate with team members, to establish an appropriate social climate, to be able to convey exemplary interpersonal skills, and to cope with what he terms “paradoxes and dilemmas”. These paradoxes and dilemmas for leadership in the virtual context include managing the challenges of, for example, having increasing access to information yet needing “to sift through a vast amount of data and weave it so that it becomes meaningful” (p. 118); having “to maintain focus and purpose in the midst of continuous change” (ibid.). He discusses “hyperlinked” versus hierarchical leadership (p 119), with leadership transformed as a result of interaction with technology. The individual heroic leader is less needed, than the skillful leader who can assume multiple roles in the service of building and maintaining a social climate in the online environment.

Boyer and colleagues (Boyer, Maher & Kirkman 2006) studied the online (typed) communications of graduate students studying educational leadership in 10 or15 week blended (online and f2f) courses to look for evidence of transformative learning on the part of the students. While they were studying an asynchronous context, they were looking for shifts in perspective, similar to the learning goals in this study. They used Mezirow’s identification of phases in the transformative learning process, and found that fundamental, albeit largely incremental changes in preconceived ideas, beliefs, habits, or assumptions had occurred for approximately one fourth of the participants (p. 351). The instructor role was found to be a vital component in the facilitation of this transformative learning. The key teaching aspects mentioned by the researchers included: timely and substantial feedback to all questions and concerns; encouragement to engage in reflection and dialogue; modelling of critical reflection; as well as the display of “empathy and concern for how others think and feel” (Mezirow as quoted in Boyer, Maher & Kirkman 2006, p. 355). They noted the need for longitudinal study of whether the experience would provide the impetus for future change, whether or not change was noted in the time frame of the study, as well as further study of what specific actions by the instructors enhance or distract from the experience.

Purvanova and Bono (2009) affirm all these aspects of online facilitation and leadership in a study of transformational leadership with teams in the virtual environment. They identify three categories of transformational online leadership: inspiring motivation through transmitting an enthusiastic vision of the collective work and its achievability; stimulating participants intellectually and encouraging their thinking about issues and rethinking of ideas; and paying individualized attention to participants through recognizing their contributions and through coaching (p. 354). They cite the importance of the creation of a sense of common mission or sense of community identity when building virtual teams, a form of virtual collaboration more structured than in this study. They also note "how the social and emotional forms of leadership are more important under [virtual] conditions where modes of communication are leaner and greater uncertainty exists" (p. 353).

Spanish researchers Fernandez and Valverde (2014) directly applied Garrison's CoI framework in the creation of a virtual learning community for Roma women. They include in their description, a useful table (cited from a presentation by Garrison and Anderson in Spanish in 2005) identifying the key implementation dimensions of the application of the three CoI presences, and how these can be seen in practice. See Table 7.1

Table 7.1 Dimensions, categories and indicators of the Community of Inquiry (CoI) model

Table 1. Dimensions, categories and indicators of Community of Inquiry (CoI) model (Garrison & Anderson, 2005)			
SOCIAL PRESENCE			
Affective	**Open Communication**		**Cohesive**
Expression of emotions Use of humor Self-disclosure	Continuing a thread Quoting from others' messages Referring explicity to others' messages Asking questions Complimenting, expressing appreciation Expressing agreement		Vocatives Addresses or refers to the group using inclusive pronouns Phatics, salutations
COGNITIVE PRESENCE			
Triggering Event	**Exploration**	**Integration**	**Resolution**
Evocative (inductive)	Inquisitive (divergent)	Tentative (convergent)	Committed (deductive)
TEACHING PRESENCE			
Instructional design and organization	**Faciliting discourse**		**Direct Instruction**
Setting curriculum Designing methods Establishing time parameters Utilizing medium effectively Establishing netiquette Making macro-level comments about course content	Identifying areas of agreement/disagreement Seeking to reach consensus/ understanding Encouraging, acknowledging, or reinforcing student contributions Setting climate for learning Drawing in participants, prompting discussion Assessing the efficacy of the process		Present content/questions Focus the discussion on specific issues Summarize the discussion Confirm understanding through assessment and explanatory feedback Diagnose misconceptions Inject knowledge from diverse sources, e.g., textbook, articles, Internet, personal experiences Responding to technical concerns

Source: Fernández, M. R., & Valverde, J. (2014), p. 99

In this research with Roma women, Fernandez and Valverde pay considerable attention to constructivist teaching presence, to the role of the teacher in instructional design, direct instruction and in facilitating discourse. They emphasize the facilitative aspect. They mention the importance of the assumption of differing roles by teachers, roles such as “debate facilitators, moderators, guides-advisors, experts answering individual and group questions, managers, etc.” (p. 101). Table 7.2 illustrates how I found all these roles of moderating, guiding, synthesizing, encouraging reflexivity, setting climate, giving feedback, modelling critical reflection relevant.

Table 7.2 – Online facilitative roles enacted

These are my quotes taken from one virtual meeting, showing the elements of facilitation. On the left are the leadership/facilitative roles assumed, and the right are the direct quotes.	
For each session I brought evidence to discuss (setting curriculum) I used questions to encourage engagement in reflective thinking (facilitating discourse)	*So the agenda for today, as you saw earlier, when I emailed you, was that -- is basically to talk a bit about young women and substance use issues and how we can bring a sex, gender, and diversity lens to the youth prevention, harm reduction, and treatment fields. [brings up table of how SGBA has been conceptualized in a process undertaken in Vancouver] Any thought from that first one? Are people aware of any place where they actually are, you know, doing this kind of thing? Of really spending time thinking about the different health consequences?*
I tried to build cohesion with mention of common journey Often it was useful to draw in participants with the use of their name, and through making reference to their points	*So lots to do, as Cathy says, and this journey we're on around trying to bring it more into the attention of the substance use field. We talked a little bit last time about the research at CAMH around the high level of benzodiazepine use amongst young girls and their substance use and mental health program there. And that issue around smoking, I don't think, is over by any means, you know, Denise, even though the rates are lower.*
Continuing a thread to prompt discussion	You mentioned the word grief as well as trauma being relevant for the girls and I just wondered if you could say a bit more about that?
Modelling reflection Offering encouragement and appreciation	In some ways, I feel like that is, a lot of this work is, to have the kind of people who are willing to walk that walk with others, of not being afraid in that moment that, when you're being questioned about your credibility or your facts or whatever, just really invite people to examine their assumptions rather than, you know, rather than losing it in that moment. And -- it just strikes me that that is a lot of the work we have before us, is to do that same kind of thing that you weathered, you know, as people have all their reasons why -- we can't or why we don't want to change.
Summarizing and focusing the discussion in this case about licit substances being those most used by girls and women, and the issues around Aboriginal girls smoking, as a subgroup of girls at particular risk	So lots to be thinking about in terms of the substances and how we approach the substances. And it's interesting that those two, benzodiazepines and tobacco, are ones that the substance use field in general haven't dealt that well with Isn't it -- isn't it interesting, eh? You wonder why this is when, you know, we so treasure our young people and want the best for them and yet we're not really consistently thinking through what is it to do good prevention with sub-groups and make it really widely known and available?
Synthesizing the discussion was consistently needed and done. Offering knowledge from other source, to encourage synthesis	Yeah. I've been reading, as a part of my graduate work, some of the work of a -- of a professor at McMaster University called Henri Giroux . . .- he's kind of a cultural-studies kind of guy, and he talks a lot about how we view youth so negatively that we're kind of coming in as a society, thinking we've got to change them, that somehow they're wrong and that, you know, they're a problem, and that we have to get them on the right path, kind of thing. And it just sounds like such a different approach that you're talking about here, of just honouring who they are and pulling out, the best of what it is to be a kid, instead of seeing them as somehow having to get on the path to quote 'responsible adulthood' or whatever, right?
Acknowledging individual contributions	Well, on that point obviously, Deb, you've really touched a very positive nerve for all of us about, you know, your work and I really appreciate you putting together the Powerpoint and sort of prompting this discussion.

Fernandez and Valverde stress how "the role played by the revitaliser of the course has been a vital one and constitutes a basic pillar for maintaining the motivation and continuous participation of the students. . . " (p. 103). And at the same time they stress how leadership in their online environment was "inverted" *(*ibid.) from a face-to-face classroom, with greater participation by students than by tutors/teachers. They note the importance of this student participation in online learning, where teachers are not intervening and participating more than students, instead are facilitating discourse, creating the space for student participatory learning. Their premise of fostering an environment where the participants speak more than the facilitator is confirmed in an evidence-based approach to guiding change on the part of clients with substance use problems. In the study of outcomes of counselling using Motivational Interviewing (Miller, WR & Rollnick 2012), it has been found that space for the client to engage in change talk, as a precursor of change in their substance use is necessary, and that this 'change talk' must be evoked by the counsellor with open ended questions and brief reflective summarizing, taking up less of the conversation than the words of the client. In this current study and in other synchronous virtual communities I have facilitated, I have found it difficult to leave the majority of the talking time to the learners, that frequent and active moderating interventions seem necessary due to the need to create boundaries for the discussion, to guide critical thinking about gender when it is relatively unknown territory, and perhaps as Purvanova and Bono suggest, due to the uncertainty created when there are less visual cues. In many ways it feels as O'Neill describes as "mentoring in the open" (2004, p. 179).

Harris and colleagues (Harris, Jones & Baba 2013) investigate the challenges of leading learning portals which support teachers' professional collaborative learning and "argue that distributed leadership is an important theoretical lens for understanding how digital collaboration is best supported and led" (p. 926). By distributed leadership practice they mean that "leadership tasks are dispersed rather than delegated and that such dispersal is widely enacted across organizations" (p. 929). The authors note that distributed leadership in the virtual world takes place "in the guise of facilitation" and "requires a form of facilitation that fosters participative decision making among all members of the online community" (p. 930). While the context of these portals differs significantly from the small synchronous community in this research, common features of leadership in these virtual environments are evident. Harris and colleagues speak of

the quantity and density of the information generated and needing consideration by the virtual community, and thus the importance for the leaders in "filtering, managing and coordinating" data. In this way they see leaders and facilitators as "boundary managers" supporting co-leadership, co-synthesis of this information, as well as reflexivity, trust and knowledge sharing. They also mention the relevance of digital collaboration where knowledge lies in different minds, in spanning "structural holes" (p. 934) - such as could be argued is the case in this study in the lack of sex- and gender-based analysis in the addictions field. In such cases the leadership in the virtual environment will need to meet new challenges in particular "will need to move easily between the individual and the collective" (p. 934).

7.5 New virtual collectivities led by boundary spanners, activist scholars and social artists

The bridging of pedagogy and technology has been considered by a number of researchers. Many like Zhu and Baylen (2005) have stressed how important it is to bridge the content, with appropriate technological supports, with facilitation that promotes interactivity. For example, while studying the integration of mobile Web 2.0 applications in higher education, Cochrane (2014) found that both lecturer modelling of the pedagogical use of web-based tools, and technological and pedagogical support were critical to the support of social constructivist learning. He underlined the role of the teacher in using a community of practice model to scaffold ontological shifts and to arrange for, if not personally act as, technology stewards. Rogers (2000) described the successful bridging of community of practice concepts (mutual engagement, joint enterprise, shared enterprise) in the design of a short term (3 week long) online workshop for professionals. Ryman and colleagues (2009) have stressed that for transformational learning to take place in the virtual environment, teachers need to actively foster "dialogic exchange that is the vehicle for social learning" (p. 42) in order for online community to serve as a location for taking participatory risks and have a social framework for achieving constructive learning outcomes. Alavi and Dufner (2005) explored a number of different technologically mediated environments and have found that many factors, in addition to the technology are important in supporting collaborative learning, including the pedagogy employed and active facilitation by the

instructors or facilitators. As has been addressed in this chapter, Garrison, Anderson and Vaughan and colleagues have offered the most complete guidance on the achievement of social, cognitive and teaching presence in blended and exclusively online environments (Garrison & Anderson 2003; Garrison & Vaughan 2007; Vaughan, Cleveland-Innes & Garrison 2013). While all of these researchers have considered virtuality and learning, none have explored the three-way integration considered in this study, of: virtuality, transformational learning in communities, and the enactment of social change by multidisciplinary learners.

It is interesting that Wenger has touched on the integration of social learning spaces – presumably online or offline - and activism in his discussion of the ethical dimension to learning, 'learning citizenship' and the leadership of 'social artists' (Wenger 2009). By learning citizenship he means "how we manage our participation in and across learning spaces" (p. 7). He sees that "this participation has both local and systemic effects . . . When we seize opportunities to participate in social learning spaces, to bridge a boundary, to convene a community that needs to exist, it is because we understand the learning potential of our location in the world and act upon it" (p. 8). He sees that enabling social learning spaces is an art and that those who excel at fostering learning citizenship in these spaces as "social artists" (p. 10). He sees that social artists are "not just good pedagogues who can help people learn something", but instead leverage the "complementarity of learning spaces and individual trajectories" (ibid.). Chapter 5 concluded with the consideration of the facilitator of online feminist action research as an activist scholar with boundary spanning skills. Chapter 6 concluded with the consideration of the facilitator of an online community with transformational learning goals as an engaged scholar with e-leadership skills. This third analytical chapter concludes similarly with consideration of the social artist displaying and engendering social, cognitive and teaching presence in online social learning spaces. As such, the role of the facilitator as boundary spanner, engaged scholar, and social artist emerged as a key unanticipated finding of this research.

The final chapter will summarize the findings more broadly and describe what all three domains covered in the analytical chapters - feminist action research, transformational learning processes in communities of practice, and online learning in

virtual communities of inquiry – have to offer to the enactment of knowledge translation on complex women's health issues.

Chapter 8 – Virtual communities as locations for knowledge exchange and feminist praxis

8.1 The conception

As a feminist and researcher in women's health and substance use, I started this study from an interest in learning more about effective approaches to knowledge translation in general and virtual knowledge translation methods specifically, based in a concern about how gender was not being adequately reflected in knowledge translation on substance use issues in Canada. I was interested in contributing to remedying this gap in the substance use field, and in contributing to an understanding of implementation of participatory mechanisms for knowledge translation on complex health issues.

The research took place in the context of extraordinary worldwide interest in improving knowledge translation in healthcare, very limited attention to gender-based analysis and action in the substance use field in Canada, and continuing global efforts by feminists to advance understanding of importance of health research, policy and practice that takes sex/gender into account. Thousands of articles on the topic of knowledge translation were written in the last two decades leading up to this study, from which to draw in the design of the community. Curiosity about communities of practice (CoPs) and virtual communities was on the rise, and literature on CoPs and virtuality emergent. Further, multiple competing views of substance use and addiction (moral, disease, disorder and public health) in operation in the addictions field in Canada and elsewhere, and multiple streams of feminism in play globally (standpoint, poststructural, postcolonial and integrative for example) contributed to a complex contextual landscape to be integrated.

I conceived of, implemented and studied a model of knowledge translation where key successes from feminist participatory action research, adult learning in community, and learning in the virtual context were braided together. I examined and brought together theory and practice from three fields in order to build and analyse a location for knowledge exchange and synthesis that would inform and catalyse action

on research and other forms of evidence related to women's health and substance use. Thus this study was about a case of a virtually located community, with knowledge translation goals, that might serve as a model for knowledge translation on complex issues such as addiction, in a way that invites gender-informed action. The research question was: "How can short-term, multisectoral, virtual communities foster the application of co-constructed knowledge on marginalized women's health, and contribute to the understanding of both knowledge translation and contemporary feminist action research?"

8.2 The foundational paradigms employed

8.2.1 Multisectoral engagement and participation

The community demonstrated that service providers, researchers and policy analysts can be reached via electronic communication, and will accept a cold call invitation to consider a topic such as gender, within a community of practice. This may be increasingly so now in the context where other forms of electronic communication (beyond email) such as Twitter and LinkedIn are in common use. Participants noted they were drawn to work in the virtual environment, to have access to others with common interests and to have the opportunity to explore issues and responses.

A key element of the implementation of the virtual community which challenged existing knowledge translation initiatives was the involvement of participants from multiple sectors and geographic locations. The community was designed to involve researchers, health service providers, health policy analysts, and others interested in the design and implementation of substance use interventions which would improve the health of girls and women. Researchers were decentered as the experts with the evidence to guide policy and practice, and instead became part of a multidirectional process of collective sharing, reflection and synthesis of multiple forms of evidence. The design acknowledged the marginalization of practitioners and policy analysts interested in sex- gender- and diversity-based analysis and action, and the resultant benefit of affective solidarity as well as intellectual validation within the critical exploration of gender informed approaches.

The conscious leveling and linking of expertise was grounded in feminist practice, similar to that in early consciousness raising groups and ongoing feminist participatory action research. Both these forms of feminist practice have valued the wisdom/evidence arising from experience, and have had the goal of making visible the concerns of women, in contexts where blindness to the operation of gender prevails. In contrast, two-way (research to practice, research to policy, or research to community) instead of multidirectional involvement and exchange often predominates in knowledge exchange and even some participatory action research efforts. The multisectoral involvement foundational to the virtual community was based in an understanding of the partial nature of any one form of evidence (from research, from practice, from policy and related experience); in an understanding of the complexities of relational and systemic change; and in the obduracy of gender blind approaches. The engagement of multisectoral participants recognized that knowledge is created in the context of relationships and knowledge and social action are produced as people learn together as active participants in the inquiry process.

8.2.2 Critical reflexivity

Each of the community's webmeetings involved introducing/locating ourselves, presentation of evidence from research, practice or policy (usually a combination), followed by discussion, questioning, modelling of sex/gender/diversity based analysis and synthesizing of implications for the contextual application of this evidence. The conceptual use of the evidence, relevant to the achievement of gender equity, over an instrumental application of evidence to any one setting was the focus. There was an acknowledgement that evidence is embedded in existing interventions as well as generated from specific research efforts, harking back to and refreshing the elements of feminist consciousness raising groups where the sharing of lived experience generated theorizing and action. The multisectoral engagement allowed for a working forward from research evidence and the successful application of gender informed approaches, backward to the nature of the resistance and the contextual challenges for implementation in various settings, and forward again based on the collective process of exploration and synthesis of evidence, clinical/policy wisdom and understanding of setbacks and successes. In essence a hybrid space was created for transdisciplinary

involvement in discussion, synthesis and action in ways that embrace complexity, embedded power relations, despair and empowerment.

8.2.3 Engaged facilitation

My role as researcher and facilitator of a community with diverse participants and undertaking such collective work emerged as more pivotal than anticipated. In general the role of researcher in participatory and collaborative research requires reflexivity and attention to navigating of the positionalities of an outsider and insider. In this case, the balancing was more complex. In taking up the guidance of the three fields of literature and in having the experience of participating in the community, I came to see my role as involving navigation among the roles of catalyst, e-moderator, boundary spanner and engaged scholar. In essence a community of inquiry grounded in the activist roots of consciousness raising and feminist participatory action research, and the more academic foundations of knowledge translation requires such multifaceted leadership stance. In this sense the role of engaged scholar in vCoI differs from all three of: the traditional research-to-practice role of the knowledge translator; the traditional educator on the continuum between sage-on-the-stage and guide-on-the-side; and the equal-as-possible participant in community-based participatory research. The leadership roles discussed in the feminist, situated and transformative learning and technologically supported learning fields all inform an engaged scholar role and draw heavily from the 'minds for the future' - disciplined, synthesizing, creating, respectful and ethical – proposed by Gardner (2008). With no lack of information and research available, the opportunity for exploring evidence, learning to apply sex/gender lenses, undertaking synthesis and forming ideas for practice with engaged scholars becomes highly relevant and utilitarian.

8.3 The analysis

In this virtual location for catalyzing research to praxis, I worked with principles of inquiry, concepts and practices from feminist theory and epistemology, situated and transformative learning and virtual learning. All three areas of theory/practice served

well to enhance understanding of how to mobilize knowledge on complex health issues, such as women's substance use.

8.3.1 From feminist theory and practice

As proposed by feminist epistemologists, the community served as an intersubjective space for communal knowledge production, where acknowledgement of experience and as well as other forms of knowledge about gender could be identified and cooperatively explored through dialogue and questioning, listening, weighing and synthesizing. Appreciation was expressed by participants for the creation of such a space where resistance to gendered relations of power could be discussed, interpreted and challenged. Thus the short-term community became a welcome and legitimate location for reflexive practice and for critical thinking on gender. Beyond the cognitive and academic benefit, the affective benefit proved important to prompting theorizing on activism. Participants were able to feel how they were undervalued in their commitment to gender-informed practice and appreciate and empathize with the commitment, challenges and successes of others in their work to address gender inequity. The community offered a space where participants could hear differences and commonalities in positions and locations in the course of collective inquiry, and consider the implications for their context and praxis, without narrowing the scope of options to a single best practice. The work of feminist theorists on diversity, border crossing and inclusion provided the guidance for effectively bringing in different perspectives and occupying and working across borders of sector, discipline, geography, and knowledge of sex, gender and diversity based analysis; and for promoting actions to resist and change the lack of action on gender in the substance use field. The understanding of border work, which has been visited and revisited in feminist theory and practice, and which supports voice, reflexive collaboration and empowerment, comprises a significant contribution to the practice of knowledge translation within virtual communities of inquiry.

8.3.2 From situated and transformative learning theory and practice

The community of practice (CoP) literature was foundational to the design of this virtual community. The term 'community' in and of itself was seen as inviting to

the participants. Many of the cited benefits of CoPs were achieved, such as facilitating access to expertise not available locally, providing the opportunity to discuss work related problems in a non-judgmental environment, facilitating access to experts, promoting knowledge exchange between members, and alleviating of a sense of professional alienation. The divergences from a traditional CoP model - time frame, distributed and multisectoral participation, facilitation, and critical attention to the external context - did not compromise the benefits. Rather, these modifications appeared to make the dialogic practice more accessible.

Beyond what the community of practice literature offered about the processes of social learning, the literature on transformative learning was utilized to understand how to support perspective change, such as coming to see the importance of gender-based analysis and action on gendered responses. Extending the CoP domains of participation, identity and community, the attention to the processes of critical reflection and collective critical synthesis offered by the transformative learning field provided direction for the facilitation of perspective shifts by participants. The transformative learning emphasis on the processes of experiencing a disorienting dilemma, undertaking self examination and critical assessment of assumptions and developing competence and confidence, added to, and affirmed, the feminist pedagogical approach of fostering dissonance about the fit between the evidence on women's health, and existing policy and service provision and feelings of solidarity in taking action.

8.3.3 From technologically supported learning and pedagogy

The virtual environment clearly bridged critical distance and time constraints and exposed participants to people with comparable interests and challenges from across the country. Importantly, the disembodiment of webmeeting participation served to level epistemic privilege and to support a focus on co-learning. The short term virtual community could be seen to be situated on a continuum between an online 'think tank' or seminar and a distance education course. The time frame - longer than the former and shorter than the latter – was designed with the aim of having just enough engagement to support shifts in perspective and commitment to action. The webmeeting platform - with its capacity to support the short term critical engagement characteristic of the think tank, and more extended learning of the online course, including online searching and

reading and chat between meetings – was designed to support learning, not only exposure to evidence. The engagement with academic as well as other forms of evidence in the online context was designed to offer both traditional academic credibility and feminist catalytic validity.

The support for virtual learning has been evidenced by those pioneering the application of the processes involved in fostering communities of inquiry to deliver postsecondary education in blended learning environments, the of support of virtual learning has been evidenced. The guidance from the CoI framework on teaching presence was particularly helpful in my own reflexive process related to balance in encouraging direction and leadership by participants, and providing leadership to ensure an effective learning experience by all. At the same time as supporting participants to fulfill their optimal roles in contributing to their own and others learning, I provided active guidance to evoke reflection and dialogue. In essence the guidance from the CoI literature freed me from focussing on equal participation by all members, to actively encouraging participation and modelling of the listening, reflection, critique and synthesis skills to be engendered.

By drawing from and braiding together three fields of expertise, I was able to implement and study a short-term, multisectoral, virtual community that fostered the application of co-constructed knowledge on marginalized women's health. The second half of the research question involves consideration of the contribution of this case of the enactment of a virtual community of inquiry to the understanding of both knowledge translation and contemporary feminist action research.

8.4 The findings about knowledge translation and feminist praxis

8.4.1 Contributing to knowledge translation

Many forms and mechanisms for translating health services research into meaningful patient care outcomes across multiple contexts have been proposed and studied. This thesis considers a mechanism for knowledge translation on a complex health issue (women's substance use) requiring the synthesis and application of evidence from multiple disciplines and locations, in a way that addresses deeply

entrenched resistance to sex/gender informed approaches. The virtual community of inquiry (vCoI) model demonstrated that it is possible to foster collaborative examination, synthesis and generation of knowledge in an accessible way. Further it illustrated that vCoIs can be welcome, needed locations for researchers, practitioners and policy analysts to come together to consider conceptual and strategic approaches to bringing evidence to practice and policy, when relations of power are working in opposition to needed shifts in the paradigms for practice.

While this case study addressed a particular health problem and its gender blind context, it can be argued that such a short-term, virtual learning community with multisectoral involvement can be helpful on many complex and gendered health issues. In the current health research funding context in Canada for example, researchers are being required to foster "the development and implementation of evidence-informed *and gender-responsive* [italics added] practices policies, services, products and programs to improve patient outcomes, access to care and quality, efficiency and effectiveness of health care" (CIHR 2014) and further to include "sex/gender champions" on research teams to achieve this. This development may make the vCoI model even more relevant.

The findings from this study show that the three core elements of the Promoting Action on Research Implementation in Health Services (PARiHS) knowledge translation framework (Kitson et al. 2008) – evidence, context and facilitation – can be employed successfully to frame vCoI outcomes. In the vCoI application related to improvement in the health response to women's substance use, the *evidenc*e needed to be multidisciplinary, and collectively considered in the light of a highly complex *context* which included the simultaneous operation of multiple models of substance use and addiction, and a continuum of gender-based responses (from gender blind to gender transformative). In such a model for knowledge translation, the third element of the PARiHS framework, *facilitation*, becomes of utmost importance. In the vCoI model, the facilitator of knowledge exchange, critical examination and synthesis of evidence must necessarily emerge in a new role beyond that of a researcher with evidence to share. Such facilitators must also be engaged scholars, skillful in creating the condition of cognitive, social and teaching presence.

The 2012 report of missing and murdered women in Vancouver n described layers of factors converging to determine these women's safety, individual narratives of violence and substance use, broad patterns of social disadvantage and exclusion, and inadequate practice and policy responses. In 2014, the World Health Organization has published global statistics on violence against women, citing how 1 in 3 women throughout the world will experience physical and sexual violence, and how women exposed to such violence will be twice as likely to experience depression and almost twice as likely to have alcohol use problems (World Health Organization 2014). The guidance for the health sector response released by WHO included identification and care for survivors, and integrated health care policy responses based on a women-centred paradigm. It is local and global health issues such as this, where mechanisms for knowledge translation with health care providers will be needed, and where vCoIs may be effectively employed. Within vCoIs, sex/gender-based analysis, discussion of responsive shifts practice and policy, consideration of contexualized action and questioning of conditions that give rise to such gendered global public health problems can be achieved.

8.4.2 Bringing CR and FPAR online

The virtual community was a conscious effort to enact and examine feminist participatory action research in the online environment. FPAR principles relating to the critical examination of gender inequities, the promotion of participation, the emphasis on inclusion and action were realized in varying degrees. The community supported participation as advanced by CR and FPAR practice. Voicing of experience, listening, active learning, acknowledging and validating of others, as well as the linking of research and experience were achieved. The value of a communal space was made visible, in how it supported listening and 'response-able' (Code 1995b) knowing. On an intellectual level participants were able to engage with how gender bias and structural inequities operate in their various contexts for women with substance use problems, for themselves as practitioners, and through the academic literature. The vCoI participation also allowed for the appreciation of others' work, empathy for what others have encountered in their practice, including the personal experience of inequities.

The work of the community, in collective SGDBA prompted a widening of the lens from women's substance use as 'the problem' to consideration of how racism, poverty, structural violence against women and other systemic forms of discrimination are at play, and the identification of more inclusive, comprehensive and nuanced responses. As such the virtual community provided opportunity for diverse participants to engage in the discussion of structural roots of substance use and addiction as problems, with the complexities of SGDBA, and even to experience equanimity in a shared 'oppositional consciousness'.

Action in the form of analysing current praxis and envisioning what should exist, as well as mentoring, inspiring synthesising, hypothesizing and even collective strategizing was apparent. We had the opportunity to act as engaged scholars in collectively synthesizing the literature, comparing it with daily clinical practice and policy making in the field, and seeing how systems of domination were in play. The opportunity to act in this way as scholars by doing collective data collection, analysis, synthesis and formulation of ideas for application to practice and policy is an important part of FPAR.

The principle of inclusion from FPAR was central to the design of this community of inquiry. The inclusion of researchers, practitioners, policy analysts and educators afforded a leveling of epistemic privilege and the needed linkage across the disciplines and sectors for transformation of the addiction field. The further diversity across race, remoteness of location, workplaces and provinces/territories served to open up discussion of options for action, and engender hope about what was and might work in many settings, challenging the use of universal, simplistic and proscriptive approaches. The inquiry came out of a concern for evidence-informed and equitable health care practice, and the 'border work' done by the diverse participants involved in this vCoI made possible discussion of how to improve the lives of women marginalized by their substance use in ways that could take into account their intersecting experiences of violence, poverty and related determinants of health. The FPAR frame – which supports inclusion, recognizes the importance of the agency of diverse participants, actively explores complexity, and acknowledges the complications of power – was in this case, a significant foundation for virtual knowledge translation practice in virtual communities.

In the early CR groups, silenced discourse was uncovered, and situated knowledge building was valued. The fundamental lessons arising from CR groups were: suppressed knowledge and/or willful not-knowing can be made visible, and that knowledge building underlying action is a relational process. The virtual dialogic space created in this study demonstrates a similar praxis of relational participation, uncovering many forms of evidence and new knowledge generation and application. Clearly the model of consciousness-raising developed the 1970s which was foundational to significant society wide change in the status of women can inform technologically supported knowledge translation practice faced with the challenge to apply what is now known about improving women's health. And the short-term, multisectoral, virtual community created and analyzed in this study, which was inspired by situated learning and feminist action research theories and practices, applied and extended them in the online context, in an iterative process of analysis and action.

8.5 Further implications

To return to the dialogue on knowledge translation initiated over a decade ago by Greenhalgh and colleagues (Greenhalgh et al. 2004), this study demonstrates that health researchers can benefit from drawing from multiple literatures and utilizing complex, more contextualized approaches to move the knowledge translation field forward. The case study described here is but one application of their recommended approach: specifically involving the use of a collective online process to enable knowledge users to become boundary spanners, who connect across distance, expertise and other forms of difference, to discuss and invent service innovations, which both address structural inequities and improve health outcomes.

This study has shown that researchers need not fear stepping outside traditional academic parameters for the transmission of evidence; that there are benefits to the uptake of the role of engaged scholar. In fact, there are solid theoretical and historical foundations for actively facilitating inter-organizational networking, knowledge sharing, collective synthesis of evidence, and collective consideration of the translation to practice and policy. Thus this study can be taken as a call to action on the part of

researchers, to focus not only on academic mechanisms such as peer reviewed journal articles, as mechanisms and indicators of success for knowledge translation. Instead, it invites researchers to embed themselves in collective processes such as communities of inquiry, balancing the focus on evidence, with that on context and facilitation.

Numerous other possibilities exist for the engagement of multidisciplinary and multisectoral knowledge users in identifying, examining, synthesizing and even co-constructing evidence. It will be important to pilot and study these independently and in relation to the approach taken in this study.

Many aspects of the use of vCoIs remain to be studied to enhance our understanding of how to achieve their engagement, critical analysis and knowledge-to-action goals. The optimal number of participants in any community, length of engagement to achieve goals, and the benefits of employing complementary technologies such as blog postings are concrete aspects, beneficial to study. Many components of the application of transformative learning principles and fostering of social and cognitive presence in virtual communities of inquiry need further study. Follow-up with participants over time may be a fruitful avenue for further research, both to reinforce learning, but also to understand how learning is applied over a longer term period than eight months, as new opportunities for application to practice and policy arise. I am encouraged as I work in cities across Canada, by the occasional connection with community participants who share stories of how participation in the community affected their praxis in the longer term, and their ever expanding commitment to relational system change. Situated evaluation of the research-to-practice outcomes achieved by participants over time will also be valuable.

Thus this study of a contemporary approach to knowledge translation, built on feminist theory and participatory research methods, situated and transformative learning theory, and approaches to learning by adults in online connective technologies, is but one experiment towards understanding knowledge translation on complex, gendered issues in our time. It was challenging and highly rewarding to undertake. I hope that I and others will have the opportunity to further apply this and related models.

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Appendix 1 – Recruitment Materials

POSTCARD – circulated at a national women's treatment conference



INVITATIONAL EMAIL – to invite community participation

Coalescing on Women and Substance Use
Linking Research, Practice and Policy

February 1, 2009

Invitation to a virtual community

This is to invite participation in a virtual community of practice (vCoP) that will examine girls' and women's substance use issues. Communities of practice are voluntary groups of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly. (See www.chsrf.ca for more info on communities of practice). The vCOP will be held over a 6 month period from February through June 2009.

In May 2008, participants in the Second Forum on the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada* in Toronto expressed considerable interest in attending to differences between women and men, and girls and boys in the implementation of the Framework. In response to this feedback, several activities that explore the role of gender as it relates to substance use and addiction have been identified, including the development of this vCoP.

The content

The vCoP will involve "virtual discussion" on key issues, cutting-edge research and innovative programming related to girls' and women's substance use in Canada. It will provide the opportunity for those already knowledgeable, and those with less familiarity, to learn of the full range of evidence on key topics related to girls' and women's substance use, to discuss it, and to consider how we might optimally apply this evidence in our work in service, research, policy and community contexts.

Topics may include:

- why we need to ask questions of sex/gender/diversity;
- how to address the gender-specific needs of young women in programs designed to reach youth;
- how outpatient counselling programs might address women's common coexisting experiences of trauma, substance use and depression; and/or
- how we are addressing the treatment needs of First Nations, Métis and Inuit women in Canada.

The topics will be finalized based on participants' interests, and discussion guides and invited speakers will support the vCoP discussions. (.

The participants and facilitators

Those working as researchers, service providers, policy makers, health system planners, and front-line service delivery workers are welcome to join the virtual community. Participants from any location in Canada are welcome to attend, as the virtual nature of the community supports wide involvement at no cost. The size of the virtual community of practice will be limited to 30 participants. Participants will be selected on a first-come, first-served basis, with some consideration given to engagement from multiple sectors, locations and organizations, if interest is high.

The vCoP will facilitated by Dr. Colleen Anne Dell, CCSA's Senior Research Associate/Academic Liaison and Nancy Poole, Research Associate with the British Columbia Centre of Excellence for Women's Health. Other researchers, service providers, health system planners and women with lived experience will be invited to present their research or practice/policy experience to the community at various points.

Getting connected virtually

For those not sure about your technical capacity to participate, it requires only a computer with high speed internet access and a phone (where you phone into a toll free number). Orientation sessions are provided to help you to get comfortable with the technology and the process.

The process

The vCoP is designed to be participatory, inclusive, focused both on our experience and the literature, appreciative of multiple perspectives, and supportive of co-learning. It is designed to help us engage with the issues and forces that have held back advancement on our response to girls' and women's substance use, and to envision how we can transform our practice as we go forth. And amidst all this, hopefully enjoyable!

We will have the opportunity to:

- Access current Canadian and international research on girls' and women's substance use and gender based analysis
- Share perspectives on promising practices on working with girls and women with substance use problems and related health and social issues
- Join up our experience and the lessons from the literature, in discussions held in webmeetings

- **If seen as relevant**, plan and deliver a webcast session to share the community's findings with a wide audience, or prepare and post a summary document, or other outputs that help all those working on the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada* to bring what we know about girls' and women's substance use into their ongoing work

The time commitment
Participation is voluntary, so participants will set their own level of participation. Five monthly webmeetings (75 minutes in length) are planned. If participants are unable to attend the webmeetings, audio files will be made available to listen to post meeting. We are hoping to hold these webmeetings at 11 am Pacific time on the last Friday of each month from February 2009 to June 2009 (or another time convenient to all those who participate). In addition, access to web-based workspace will allow for access to documents and online discussions.

The sponsors
The project is sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA).

How to get started
To indicate your interest in participating in this virtual community of practice, please contact Nancy Poole at the address below by February 7, 2009.

Nancy Poole
Phone: (250) 213-8144
Email: wavelength@telus.net

Evaluation and research
As well as co-facilitating this community, Nancy Poole will be documenting it as part of her doctoral research with the University of South Australia. The focus of the doctoral research is to understand the potential of short-term virtual communities in fostering the application of co-constructed knowledge in ways that improve the health of girls and women.

For the purposes of the doctoral study, 4-6 months post community, participants will be invited to fill out an online survey, and to attend a virtual focus group to discuss their experience in bringing the community's work into their daily work as researchers, service providers, health system planners, policy makers and community-based advocates. *Participation in this post-community research is entirely voluntary.* This project has been approved by the University of South Australia's Human Research Ethics Committee.

We look forward to working with all those involved in the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada* and others who may be interested.

With respect,

Colleen Anne Dell, Senior Research Associate/Academic Liaison, CCSA
Nancy Poole, Research Associate, BCCEWH
Janice Mann, Director, Knowledge Exchange, CCSA
[logos included of CCSA, BCCEWH, University of South Australia and University of Saskatchewan (Colleen's workplace)]

Appendix 2 – Post-community Focus Group

EMAIL INVITATION

To: Members of the virtual community on women and substance use issues, held Sept. 2008 to March 2009

Subject: Invitation to the post-community virtual focus group

It has been [insert number] of months since we worked together in a virtual community of inquiry on issues related to girls' and women's substance use. This is to invite your voluntary participation in a virtual focus group on the topic of this experience, and possible follow-up action(s) you have taken as a result of participation in the virtual community.

The focus group will use the same webmeeting format that was utilized in the course of the community.

The virtual focus group will be held during the week of [date] at a time convenient to all those who volunteer. It will involve approximately 60-90 minutes of your time.

The focus group is related to my doctoral study with the University of South Australia on virtual communities as locations for catalyzing research to praxis. Please see the attached information sheet for more information on the research purpose, the virtual focus group, and ethical practices.

Please contact me by [date] to let me know of your interest in participating.

Thanks

Nancy Poole
Doctoral student, University of South Australia UniSA
Research Associate, BC Centre of Excellence for Women's Health, BCCEWH
Phone: (250) 213-8144
Email: wavelength@telus.net

Attachment – Research Information Sheet

FOCUS GROUP QUESTIONS

Project title - Virtual communities as locations for catalysing research to praxis

1. What type of work related to the issue of girls, women and substance use do you do?
2. Looking back, how do you view the *virtual* aspect of the community – how did it contribute to, or hold back our connection as participants, our discussion of issues, and our development of consensus resources?
3. What insights into the issues we discussed arose for you? How/did your perspective on addressing issues affecting girls and women with substance use problems change?
4. Did the community participation affect your network of contacts, your collaborations, or your interests in connectivity to others in the field in any way?

5. How did the diversity of the community membership work from your perspective? Was it inclusive of the requisite points of view? Did a sense of bridging of these views, or a sense of community develop?
6. What did the community co-create in the way of tools or consensus documents? How do they differ from resources that might be created by a person from one sector or perspective only, or by drawing on academic literature only? How/have you used them?
7. What post community action have you taken, individually or collectively on improving the response to girls and women with substance use and related health and social problems or applying gender based analysis in your work? Do you have further plans for action on the issues and learnings arising from the participation?
8. Other comments on how/if participation in the community has affected your approach to your work overall?

Trauma-Informed Approaches in Addictions Treatment



Gendering the National Framework

In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a "virtual discussion" of issues, research and programming related to girls' and women's substance use in Canada. The goal of the vCoP was to serve as a mechanism for "gendering" the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada*. Participants included planners/decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP. Its purpose is to stimulate further conversation on addressing coexisting trauma, mental health and substance use problems experienced by girls and women through trauma-informed and trauma-specific approaches.



Background to the issues

What we know about the connections of substance use and experience of trauma

The inter-relationships of trauma/violence, mental illness and substance use in women have been described by researchers as "profound" and "staggering" [1, 2]. 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 [3]. A Washington DC study showed that over 70% of women with mental disorders have co-occurring substance use problems and virtually all women with co-occurring disorders have a history of trauma [4].

The implications of these interconnections are significant, relating not only to emotional health and well being, but all areas of women's lives, including physical health and mothering. Experiences of trauma are linked to central nervous system changes, sleep disorders, cardio vascular problems, gastrointestinal and genito-urinary problems, reproductive and sexual problems [5]. Physical health may also be affected by self-harming behaviours as attempts to cope with emotional pain [6]. Women are in a unique position when it comes to pregnancy and mothering, yet little attention has been directed to the needs of mothers in the context of co-occurring mental illness, substance use problems and experience of trauma [7, 8]. Women may experience the trauma of having a child removed, or threats by a partner to report her to child welfare authorities. The stigma attached to violence and substance use in relation to pregnant and parenting women can prevent or delay help seeking [9]. This can be magnified for women who find themselves even further in marginalised positions (e.g. poverty, colonization).

The literature over the past decade has emphasized the centrality of the experience of interpersonal victimization including childhood abuse, sexual abuse, and intimate partner violence for women with mental health problems and addictions [3, 10]. Women are at greater risk than men for interpersonal victimization [11-13], and a recent meta-analysis found women to be twice as likely to develop PTSD after a traumatic event and the chronicity of symptoms for women to persist up to 4 times longer than for men [14].



Current responsiveness to the interconnections

The links and interactions among experience of violence and trauma, mental health concerns and substance use problems and addictions are not typically addressed in total, nor do system responses typically start with a sex, gender or diversity based understanding of these issues. At the local level, service systems are often characterized by; service fragmentation, compartmentalization, competing and contradictory service approaches within mental health, substance use and violence support services. Women report being turned away from mental health and addictions counselling services for having more than one presenting issue, and are left too frequently to personally coordinate their care [15, 16]. In addition, there is often a basic lack of understanding of how trauma can be central to the co-occurrence of mental health and substance use problems, and consequently there is often a lack of services providing trauma-specific treatment, a lack of paced and evidence-based approaches to trauma treatment (trauma-informed interventions), especially within substance use treatment programs, as well as significant barriers to access treatment by women with children [17]. The lack of attention to effects of trauma and their connection to alcohol, tobacco and other drug use, and mental illness can lead to misdiagnosis, extended suffering and even retraumatization. The cost is significant for individuals, for families, for service systems and for governments.

Key national and international articles and reports have continued to identify opportunities and barriers to an integrated and coordinated service response [18-24]. In Canada we have a long way to go towards building a seamless, compassionate, integrated response.

The most notable example of an examination of an integrated cross/system response has been the cross-site study entitled the *Women, Co-Occurring Disorders and Violence Study* (WCDVS), funded by the Substance Abuse and Mental Health Services Administration in the US. Over a five year period, nine sites across the US were studied as they developed and tested integrated service models that were comprehensive, trauma-informed, and gender-specific. They found that:

- women with complex co-existing problems experienced reductions in trauma symptoms, drug use severity and mental health symptoms when integrated models that were trauma-informed and financially accessible were provided [25, 26];

- integrated counselling in a trauma-informed policy and service context was more effective than services as usual [27-29]; and

- complex collaborations including consumers, providers and system planners in all aspects of the policy design, implementation and evaluation of services improve the quality of the work [30-32].

- Costs of such integrated care were not higher [33].

Canadian and American service system experts stress how we need to *"address global service issues including: stabilizing and regenerating the core continuum of services; addressing gaps in specific categories of services; and meeting needs for specialized, gender-specific service approaches in service areas such as concurrent disorders, pregnant and parenting women, and trauma*" [24]. Integration at multi-levels – outreach and engagement, screening and assessment, resource coordination and advocacy, crisis intervention, mental health and substance use services, trauma specific services, parenting support, and healthcare were advocated in the WCDV study [32, 34, 35]. Many other integrations, for example, across substances (including tobacco), across sectors (to include women and health system planners as well as service providers), and to include policy [36] improvements have also been identified.



Core approaches – multilevel, multiple-intensity support

Working at all tiers of support - To successfully "gender" the National Framework, we need to address programming and practices at all 5 tiers of support/treatment as outlined by the National Treatment Strategy Working Group:

Tier 1 - Community based and outreach services
Tier 2 - Brief support and referral by a wide range of professionals
Tier 3 - Acute, proactive outreach and harm reduction services
Tier 4 - Structured and specialized outpatient services
Tier 5 - Intensive residential treatment
(For more description of the tiers see http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf)

Working in different ways - To address trauma and interpersonal violence which often underlies women's use of substances, we can:

a) Be trauma-informed at each tier of support/treatment
b) Offer integrated trauma-specific programming, using evidence-based models
c) Link effectively with violence-specific services such as transition houses and sexual assault centres

This approach moves toward a holistic, instead of a closed or narrow understanding of the intersections.

Trauma-informed services take into account knowledge of the impact of trauma and integrate this knowledge into all aspects of service delivery [37]. From a trauma-informed perspective, "problem behaviours" are understood as attempts to cope with abusive experiences. Disorders become *responses*, and symptoms become *adaptations* [5]. The question shifts from "What is wrong with this woman?" to "*What happened to this woman?*" [38]. Working in a trauma-informed way does not require disclosure of trauma nor treatment of trauma, it is about working in ways that accept where the woman is at and do not retraumatize.

Trauma-specific services directly address the impact of trauma and facilitate trauma recovery and healing. Initial stages of treatment emphasize safety, identified by Herman in 1992 as the critical first stage of recovery. *Seeking Safety* [39] and *Beyond Trauma* [40] are two evidence-based program examples that take an integrated approach to supporting women with trauma and substance use concerns. The recognition of the centrality of trauma in Aboriginal women's healing has been noted in Canadian research and practice [41].

Promising practices in action – Canadian examples

1. The work of the Jean Tweed Centre, Toronto, ON – Tier 5

The Jean Tweed Centre has evolved in their response to women in treatment for addiction issues - from recognition of trauma experiences in the women they were supporting, to providing trauma-informed and trauma-specific services [42]. They transformed their services in a four stage process.

Stage 1 – Addressing the issue
Through tracking, they noticed that over 80% of their clients had a trauma-related experience. With this information, and influenced by the work of Judith Herman (1992), program leaders began to research the topic and address the issue through:

1) Education – they provided education for the staff and invited the Ministry of Health funders to be part of the learning
2) Proposal development –they received funding for a clinical supervisor and trauma counsellor
3) Evaluation – they noticed that using standard approaches to raising the issue of trauma connections may in some cases be creating instability, not helping women stabilize

Stage 2 – Shift to trauma-informed
Services shifted from standardized screening and discussion of trauma, to a more "trauma-informed" approach. Service providers became much more knowledgeable about the issues, and focused on creating a safe environment which would support women to tell their story in their own ways, in their own time.

Stage 3 – Depth and capacity
Looking to deepen their capacity to support women who experience trauma, staff were offered more indepth training in the practice of Mindfulness and the Seeking Safety model, which combines first stage trauma treatment and relapse prevention. Now, 1) all programs at the Centre are trauma-informed 2) Seeking Safety groups are offered to all women, and 3) a dedicated trauma counsellor provides individual counselling for women and consultation/education with staff.

Stage 4 – Continuing braided support
Emphasis is placed on integrating and braiding trauma and substance use services throughout the Centre, for example trauma experienced by pregnant and parenting women who access the Pathways program (for pregnant and/or parenting women with children aged 0-6 yrs who have issues with drugs or alcohol) is addressed. Overall, the key aspects of the braided approach include:

- Ongoing staff education
- Support for women's pacing – no prescribed timetable or sequence for dealing with trauma issues – look to the woman for readiness
- Good clinical supervision
- Peer support for staff and clients
- Evaluation – good quality assurance plan

2. The Seeking Safety model in practice at the Victoria Women's Sexual Assault Centre (VWSAC) – Tier 4

VWSAC service providers noticed that women with trauma-related mental health and substance use problems were often in crisis and accessed a variety of services to get their needs met [15]. In response, VWSAC initiated a community collaboration to provide integrated services for women. Linking with the Vancouver Island Health Authority, a trauma counsellor and an addiction counsellor deliver outpatient groups based on an adapted version of the *Seeking Safety* model. Recognizing the needs of the women for basic coping skills as well as more in-depth group support, they offer 2 stages of groups:

1) Seeking Information – 3 weeks, focus on coping strategies
2) Seeking Understanding – 12 weeks, examine specific topics related to trauma and substance use in more depth

The Seeking Information group offers an opportunity for women to make an informed choice about their readiness to commit to the Seeking Understanding program.

Participants have noted many positive impacts of these groups that integrate support for women on trauma and substance use issues including:

- Opportunity and safety to explore trauma and substance use
- Learning about the effects of trauma and skills to manage
- Reduction in stigma and increasing self acceptance
- Breaking through isolation, connecting with other women
- Developing hope for the future [15]

The experience of the Victoria Women's Sexual Assault Centre exemplifies the importance of linking with violence specific services and the possibility of integrating trauma-specific and substance-informed approaches in a community-based context.

3. Offering outreach and harm reduction services for pregnant and parenting women – Tier 3

It is important to help women who use substances when pregnant to reduce harms associated with determinants of health such as food and housing insecurity, racism, rigid mothering policies as well as experiences of violence, abuse and trauma. Service providers across BC who work with pregnant women and new mothers were receptive to this broad view of harm reduction when engaging in training through the ActNow BC Healthy Choices in Pregnancy (www.hcip-bc.org) initiative 2004-2009 [43].

Many outreach programs for high risk pregnant and parenting women, such as the Sheway program in Vancouver (www.vch.ca/women/sheway.htm), the Enhanced Services for Women program in Alberta (www.aadac.com/547_1221.asp) and the Pathways to Healthy Families program in Toronto (www.jeantweed.com/i-pathways.asp), provide services focusing on the broader determinants of health, recognizing the link between trauma, mental health and substance use. The common thread in these programs is the emphasis on paced, collaborative work with women - integrating harm reduction and trauma-informed approaches.

4. Trauma-informed brief interventions – Tier 2

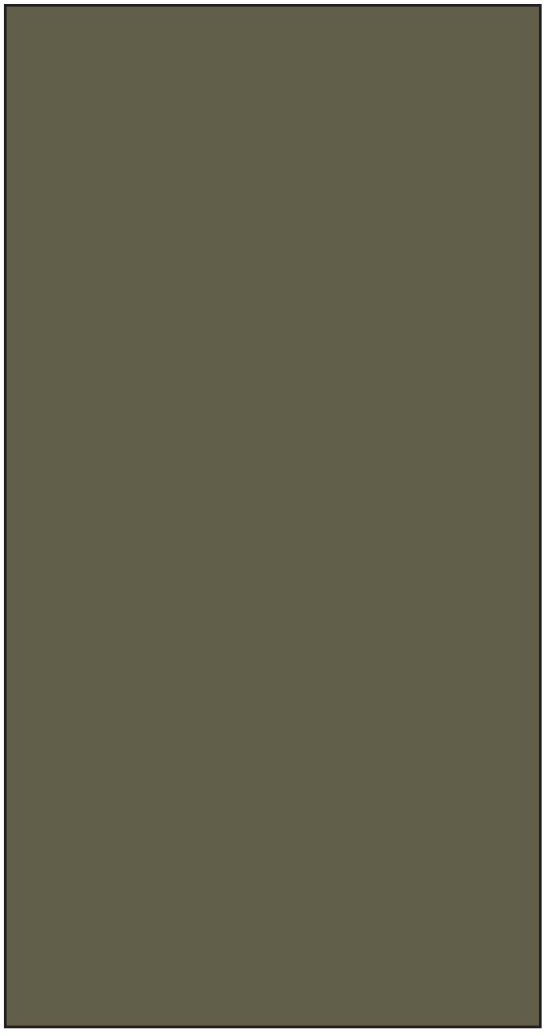
Professionals who are not addiction or trauma counselling specialists, play a critical role in providing brief support to women and identifying those who may need more intensive services. A promising practice at this level is using a motivational interviewing (MI) style of communication to support engagement and positive change within brief interventions [44]. There is substantial evidence for the use of motivational interviewing approaches in brief intervention with diverse groups/cultures and a range of women's health concerns [44-47].

There are many parallels between MI and trauma-informed approaches [48]. Collaborative relationships, characterized by power sharing and safety are at the core of MI and trauma-informed approaches. Both emphasize empowerment by focusing on strengths and building self-efficacy. Respect for choice and understanding a survivor's perspective are noted as key to supporting women in making changes and recovering from trauma. The MI principle of "resisting the righting reflex" relates to the trauma-informed principle of avoiding revictimization. The "righting reflex" is the desire to fix, make better or even protect - particularly in the context of violence. This reflex can lead service providers to try to persuade women to make changes and control decisions for them, consequently becoming the source of revictimization.



5. Peer support – Tier 1

Peer support models are an important part of the treatment continuum and are noted to be particularly effective for women [49]. Recognizing that the needs of many women were not being met by traditional peer support models, Charlotte Kasl (www.charlottekasl.com) created the *16 Steps for Discovery and Empowerment* groups. The 16 steps approach is holistic [50]. At its core, this model is based on love not fear; internal control not external authoritarianism; affirmation not deflation; and trust in the ability of people to find their own healing path when given education, support, hope and choices. In the 16-step model, addiction is understood as a combination of social and physical factors, pre-disposition and personal history. A key task of healing from addiction is recognizing and honouring the underlying positive survival goals of safety and connection, and finding healthy ways to meet those needs [50].





Discussion questions on providing integrated approaches

The following questions are intended to support direct service providers, program leaders and system planners to reflect on their current practice, policies and procedures.

1. What have you noticed about the links among trauma, mental illness and substance use problems from your experience of supporting women with these and related challenges?

2. Does your service assume that violence has played some role in the woman's/girl's life, even if she has not identified abuse as a source of difficulty?

3. How does your service currently address the needs of girls and women experiencing trauma, substance use and mental health concerns?

4. Does your service provide training to women accessing services in skills useful to healing from trauma as well as substance use and mental health concerns - such as self-soothing, self-esteem, self-trust and assertiveness?

5. Has education (basic information about trauma and its impact) been offered to all staff at your service? Have clinical staff received training on specific modifications of existing services for trauma survivors?

6. What opportunities are there for building awareness/taking action to improve the response for girls and women with substance use problems and related trauma and mental health concerns?

7. Notice the language used within your context. What would happen if 'symptoms' were reframed as 'adaptations'? How would things change at a practice and policy level if 'disorders' were considered 'responses'?

8. Improving the system of care for girls and women requires a paradigm shift from "what is wrong with her?" to "what happened to her?" Consider what this shift might mean for your services or system.

9. How does your organization support efforts to minimize the possibility of re-traumatization?

10. In what ways are girls and women involved in the development of service policies and protocols?

11. How is diversity, such as one's cultural background, considered in the trauma-specific services you offer?

To access additional tools for assessing your service for being trauma-informed, see the Trauma-informed Toolkit developed by the Klinic Community Health Centre in Manitoba www.trauma-informed.ca/., and checklists adapted from Harris and Fallot [37] developed by Dr. Vivian Brown (Guidelines for Trauma-Informed Assessment) and Dr. Stephanie Covington (Services for Women and Girls: Trauma-Informed Inventory)

Weblinks

Canada

Aboriginal Healing Foundation
www.ahf.ca/
The Aboriginal Healing Foundation offers resources to support the healing process of Aboriginal people and their communities. The website hosts comprehensive research documents outlining the historical context of trauma and ways forward.

CAMH Building Responses
www.camh.net/Publications/Resources_for_Professionals/Bridging_responses
Developed by the Centre for Addictions and Mental Health in Ontario, Bridging Responses is a resource for front-line staff who work with women — in health care, literacy, corrections, housing and community services. It offers information and tools to help recognize responses to post-traumatic stress in women's lives, and to establish a level of confidence that encourages women who have survived abuse and violence to consider referrals to appropriate services or resources. The electronic version is available at no cost. The hard copy booklet can be ordered for $5.95 each from CAMH.

Coalescing on Women and Substance Use
www.coalescing-vc.org
This website highlights online "virtual" discussions on six key topics related to women's substance use in Canada including the response of violence services' to substance use, and the response of addiction services' to violence. There are a number of helpful information sheets outlining key points and resources related to each topic.

Klinic - Trauma-informed Toolkit
www.trauma-informed.ca
This Toolkit, developed by the Klinic Community Health Centre in Manitoba, provides information on all aspects of trauma including what it is, its impact, effective approaches to working with people who have experienced trauma, trauma recovery, the impact on service providers and organizations, self assessments to determine whether organizations are trauma informed and information on resources and training. The Toolkit can be downloaded at no cost from the website or purchased in hard copy for $15.00 each.

US

Beyond Trauma
www.stephaniecovington.com/books.asp
Developed by Stephanie Covington, Beyond Trauma is a treatment manual based on theory, research and practice experience. Emphasis is placed on coping skills and the connection between trauma and substance use is noted throughout. The manual can be ordered from the website.

Institute for Health and Recovery
www.healthrecovery.org/projects/trauma_integration
A service, research, policy and program development agency that works from gender-specific, trauma-informed principles. One of their key projects is trauma integration.

National Trauma Consortium
www.nationaltraumaconsortium.org
The goal of the NTC is to raise awareness about trauma and its impact on people's lives. This website has a number of helpful publications on integrating services for women which can be downloaded at no cost.

SAMHSA`s National Mental Health Information Center
www.mentalhealth.samhsa.gov/nctic/trauma.asp
This site provides an overview of trauma, description of trauma-informed care and links to trauma-specific interventions. Details of the Women and Co-occurring Disorders and Violence study and related publications can be found here.

Seeking Safety
www.seekingsafety.org
Developed by Lisa Najavits, Seeking Safety is an evidence-based, present-focused, integrated therapy approach for treating trauma/PTSD and substance abuse. Emphasis is placed on establishing safety in the early stages of healing. Sample topics can be viewed online and the manual can be ordered from the website.

UK

Women`s Aid
www.womensaid.org.uk/landing_page.asp?section=000100010010000400020002 0003
This site outlines comprehensive good practice guidelines for violence services working with women who use substances and for drug and alcohol services working with women experiencing violence.

Summary

This discussion guide - with its background to the issues, overview of multi-level, multiple-intensity support, presentation of promising practices in action in Canada, discussion questions and weblinks - has been prepared to assist individuals and agencies who are working on the *National Framework for Acton to Reduce the Harms Associated with Alcohol and other Drugs and Substances* with gender based analysis. Hopefully it will catalyze both analysis and action on gender- and trauma-informed work by those working on the Framework and others interested in improving policy and practice related to substance use and addiction.

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British Columbia Centre of Excellence for Women's Health
E311 - 4500 Oak Street, Box 48
Vancouver, British Columbia V6H 3N1
Canada

Email: bccewh@cw.bc.ca

Download this document at:
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Girl-Centred Approaches to Prevention, Harm Reduction, and Treatment

In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a "virtual discussion" of issues, research, and programming related to girls' and women's substance use in Canada. The goal of the vCoP was to serve as a mechanism for "gendering" the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada*. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP. Its purpose is to stimulate further conversation on gendered approaches to youth prevention, harm reduction, and treatment.



Gendering the National Framework



Background

Increasing attention is being brought to the issue of substance use by girls and young women, and the associated health and social consequences of heavy drinking, smoking cigarettes, as well as the use of both licit and illicit substances. Historically young men have been more likely than young women to drink alcohol, smoke cigarettes, and use illicit substances, but local, national, and international data now show that this gender gap in substance use is closing.[1]

Participants in the virtual Community of Practice (vCoP) discussed four topics related to young women's substance use: 1) patterns and trends in young women's use, 2) sex differences in the health consequences of use, 3) gendered influences on substance use, and 4) examples of gender-informed and gender-specific programming. An overview of these four topics is presented here, followed by a list of questions that emerged from this information. Reviewing and reflecting on this list of questions may facilitate the application of a gender-based analysis to addictions prevention, harm reduction and treatment programming and policy.

Patterns and trends in young women's substance use

Alcohol – According to the 2004 Canadian Addiction Survey, over 85% of the alcohol consumption reported by females aged 15–24 is consumed in excess of Canadian guidelines. In this survey, 15% of young women aged 18–19, and 11% of women aged 20–24 reported heavy, frequent drinking.[2] Additionally, there are subgroups of girls and young women at higher risk, for example the 1992, 1998, and 2003 BC Adolescent Health Surveys show that "compared to heterosexual youth the same age … bisexual females were two times more likely to report binge-drinking."[3]

Cannabis – Approximately 10% of Canadian women report cannabis use in the past year.[4] Use by young women is much higher than this average: Twenty–seven per cent (27%) of young women in the 15–17 age group, 43% in the 18–19 age group, and 30% in the 20–24 age group report using cannabis in the past year. While young men use cannabis at higher rates than young women, the age group with the least difference in rate of use is the 15–17 age group where 31% of boys report use compared to 27% of girls.

Tobacco – Historically, men have always smoked more than women. However, now a higher proportion of young women aged 18–19 smoke (24.4%) compared to young men (22.2%).[5] Women are also starting to smoke at a younger age.[6] Tobacco use rates for the Aboriginal population over 20 years are more than double the Canadian average.[7] Smoking among Aboriginal girls in BC is higher than Aboriginal boys [8] and the age of smoking initiation is youngest for Aboriginal girls (age 10).[9]

Licit drugs – Women have always been prescribed mood altering medications at higher rates than men.[10] A recent study by the Centre for Addiction and Mental Health found young women aged 16–24 who were entering treatment in their Youth Addiction and Concurrent Disorders Service were prescribed or taking benzodiazepines at an alarming rate: 43% of young women versus 12.5% of young men.[11]

Health impacts of young women's substance use

Women are at risk for accelerated development of long-term health problems associated with heavy substance use, such as liver disease, cardiac problems, cancers, gastrointestinal problems, brain damage, and addiction.[12, 13] As well as setting the stage for these long-term impacts, substance use during adolescence has certain gender-specific risks. For example, substance use can negatively affect puberty and disrupt normal sexual reproductive functioning.[14] A key sex difference for young women of child bearing age who consume alcohol and use other substances is the risk of unwanted, unplanned, or unintended pregnancy due to unprotected and unplanned sex. Intoxication can make young women more vulnerable to date rape, sexual assault, and unprotected sex, [15, 16] and increase their vulnerability to HIV and sexually transmitted infections.[17] We are in the early stage of applying a sex, gender, and diversity lens to research on the health impacts of substance use, but unquestionably sex differences in health consequences of substance use are significant.

Gendered influences

As yet, there is not a large literature on influences and pathways to substance use by girls. In 2003, The National Centre on Addiction and Substance Abuse published *The Formative Years* report,[18] a groundbreaking study on the pathways to substance use for girls and young women. This study identified key influences on girls' and young women's substance use that can be categorized into four domains: personal attributes, attitudes, and childhood experiences; peer and school influences; family, culture, and community; and societal influences, such as media advertising. Four recent (2008–9) studies are described here to illustrate key gendered influences and pathways as well as key protective factors for girls and young women:

Depression, obesity, and alcohol use

A recent study on the longitudinal associations among depression, obesity, and alcohol use disorders in young adulthood identified links among all three in young women. [19] The study found that, "women with an alcohol disorder at age 24 were more than three times as likely to be obese when they were 27. Women who are obese at 27 were more than twice as likely to be depressed when they were 30. And women who are depressed at 27 were at an increased risk for alcohol disorders at 30."[20] The researchers suggest that the connection between alcohol use and obesity may be due to increased caloric intake with drinking alcohol or substituting food for alcohol. Alcohol abuse is noted to be common among women with bulimia [21] and research shows that monthly binge drinkers on average have waistlines half an inch larger than those who drink the same amount of alcohol over the course of a week.[22]

Violence and victimization

In describing trauma-informed approaches in addiction treatment, Covington [23] identifies that in childhood, boys and girls are at equal risk of physical and sexual abuse by family members and people known to them, however, this risk shifts in adolescence. The age of greatest risk for sexual assault for girls is fourteen; for boys it is five. In adolescents, boys are more likely to be harmed by enemies or strangers, experience violence based on race, sexual orientation, or gang affiliation. Girls, on the other hand, are at greatest risk of harm by those closest to them, with whom they are in relationship with, care for, and love. This pattern continues into adulthood. Covington suggests these differences, particularly the likelihood to be harmed by someone you know or care about, may account for greater mental health problems for women, and underscores the necessity for interconnected, gender-responsive substance use services.[23]

Peer influences

LaBrie and colleagues [24] used a web-based survey to examine how much heterosexual female college students believe their male peers want them to drink, compared to how much the male students actually prefer them to drink. The study found that the females significantly overestimated (nearly double) the actual amount of alcohol males prefer them to drink, and that this misperception is associated with women drinking at risky levels. Rather than drinking to be equal to men, the study suggests that women are drinking to be liked by men; therefore sharing normative feedback may be a promising intervention.

Key protective factors

To better understand gender-specific risk and protective factors for substance use, Schinke and colleagues [25] surveyed adolescent girls and their mothers about substance use and related concerns. From their study, they identified the following key gender-specific protective factors:

- Going home after school
- Positive body image
- Mother's knowledge of daughter's whereabouts and companions
- Girl's ability to always contact her mother
- Family rules against substance use and parent encouragement to abstain

Similarly, the protective role of parental attitudes and fear of consequences were noted in a recent report on youth and alcohol use in Nova Scotia.[26]



Examples of gender-informed prevention & treatment for girls and young women

Although information on gender-informed prevention and treatment for girls and young women is limited, some promising programming is available for treatment service providers, prevention workers, and health system planners to draw upon. Provided below are five examples of promising directions in gender-informed programming for girls and young women. These examples highlight programming that addresses key influences and known protective factors for girls and young women in a range of contexts.

Peer support

CAMH, Validity Project – What young girls want you to know about depression

(www.camh.net/Publications/Resources_for_Professionals/Validity/validity_reframing.html)

This project is an example of reframing prevention through the voices of girls and young women. It was created for-youth by-youth in response to the reality that in early adolescence depression becomes more prevalent for girls than boys, and this discrepancy is even more pronounced in later adolescence. The project empowers young women to move beyond a purely medical understanding of their depression, and encourages them to share their knowledge and insights about risk and protective factors.

For the young women in the project, support is a key source of prevention connecting with each other and connecting with caring adults who listen. With this understanding, a number of prevention programs have evolved from the Validity Project, including Girls Talk, a facilitated, peer support group for girls. The goals of the program are to support safety and connection, and to strengthen protective factors such as healthy coping skills and positive body image.

Virtual empowerment

Girls Inc.

(www.girlsinc-online.org)

Girls Inc. is a non-profit organization that empowers girls to be strong, smart, and bold through education, advocacy, and research-based programs. The organization started in the United States and there are now programs in Alberta and Ontario. Girls Inc. has a strong virtual component that encourages girls to explore different topics such as exercising the mind, knowing one's body, and planning for the future. A Girls' Bill of Rights and recent public education campaign messages are also posted on the website. It is free for girls to become members and participate in the various activities.

Family connection

Computer-delivered substance use prevention program for adolescent girls and their mothers

Developed by Schinke and colleagues [27] this program seeks to affect risk and protective factors for substance use by strengthening mother-daughter interactions. On a weekly basis, mothers and daughters work together to complete a 45 minute computer-based session focused on topics such as building communication skills, self-image, and setting rules around substance use. Each session is computer-delivered and uses voice-over narration, animation, and interactive exercises.

In a randomized study of the program, benefits were noted at the two year follow-up for both daughters and mothers. Compared to the control arm dyads, girls who received the computer-based intervention reported lower risk factors and higher protective factors, and their mothers reported lower weekly rates of alcohol consumption.

Community connection

Communities That Care

(www.ctcsquamish.com)
Communities That Care (CTC) is an evidence-based prevention project that engages all areas of the community in promoting the positive development of youth. The comprehensive, community-wide approach reflects an understanding that one's broader social context plays a role in the experience of substance use. The goal of this approach is to reduce risk, increase protective factors for children and youth, and strengthen related environments including home, school, peer groups, and the community.

Youth are encouraged to take an active role in community efforts. In this type of approach there is the potential to support leadership by young women and to have an effect on multiple gender-specific influences on girls' and young women's substance use.

Priorities and programming vary depending on each community's needs. For example, the Squamish CTC project has identified five areas for prevention: substance abuse, delinquency, unintended teenage pregnancy, academic difficulty, and violence and depression. The Squamish community has worked on initiatives that address prevention needs in these areas, including offering the *Strengthening Families* program to parents and their children.

Gender-specific treatment

Youth Solvent Addiction Committee

(www.ccsa.ca/eng/partnerships/ysac/Pages/default.aspx)
In the mid 1990's media attention raised concern about widespread solvent use on First Nations Reserves across Canada. As a result, Health Canada established six First Nations youth treatment centres. Not all centres started out with gender-specific programming, but the outcomes quickly highlighted the benefits of taking this approach. The centres with gender-specific treatment recorded lower incidents, better retention, faster engagement with the program, and increased participant satisfaction and therapeutic alliance.

Gender-specific approaches are now evident at all levels of treatment in the Aboriginal Youth Solvent Abuse Treatment Centres, including data collection, programming, and staffing. Data that has been analyzed by gender has helped to shape policy and program decisions. For example, noting that girls and young women were reporting higher rates of trauma, the girls' services are trauma-informed and led by women. The services emphasize an empowerment approach, single gender group sharing, and specific traditional teachings.

Discussion questions

The following questions are intended to support direct-service providers, program leaders, and system planners in reflection on their current practices, policies, and procedures.

What we know…	What needs to be considered…
Overall, substance use is increasing for girls and young women, and in some cases surpassing rates for boys.	How does this fit with your experience? Why is it important to know this type of information?
Pathways to substance use differ for girls and boys, and girls face distinct challenges, such as higher rates of depression and trauma, poor body image, risk of pregnancy, and so forth.	How might this influence universal prevention campaigns and messaging? What are some ideas of how to make messaging more gender-specific? How might you reach girls and young women at different levels of development, risk, etc?
Tobacco and alcohol advertisers target girls and young women through concerns about appearance and a desire to connect with others.	What can be done in your service or program to reduce media influence and strengthen protective factors for girls and young women?
Positive connections with adults and healthy peer support are protective factors for girls and young women.	How are these connections currently being fostered? How might this influence programming and policy?
Research shows that girls overestimate the amount of alcohol that boys want them to drink, and the amount of alcohol their peers drink.	Why is this information important? How would you use this information to help tailor programming for girls? What would be an essential component to include in programming?
Mental ill health, substance use, and experiences of violence and trauma are closely connected for girls and young women.	How are these interconnections addressed and supported in your program, service, and policies? How might the response be improved?
Not only is it important to strengthen individual protective factors, but also to strengthen the environments that influence girls and young women including home, school, peer and community.	What prevention initiatives are happening in your community? Do they take a gender-informed approach? What is working? What are areas that could be developed? How are youth involved in community prevention efforts?

Summary

This discussion guide was prepared to assist individuals and agencies working on the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances* with the application of gender-based analysis. Hopefully it will be a useful resource in the development of "gender-informed" prevention programming, harm reduction initiatives and treatment directed to young people, by those working on the Framework, and by others interested in improving policy and practice related to substance use and addiction in Canada.

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British Columbia Centre of Excellence for Women's Health
E311 - 4500 Oak Street, Box 48
Vancouver, British Columbia V6H 3N1
Canada

Email: bccewh@cw.bc.ca

Download this document at:
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Mothering and Substance Use: Approaches to Prevention, Harm Reduction, and Treatment



Gendering the National Framework

In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a "virtual discussion" of issues, research, and programming related to girls' and women's substance use in Canada. The goal of the vCoP was to serve as a mechanism for "gendering" the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada*. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP. Its purpose is to stimulate further conversation on addressing the needs of pregnant women and mothers in substance use prevention, harm reduction, treatment, service system planning, and policy making.



Background

Mothers and pregnant women with substance use problems face multiple barriers in accessing support and treatment services. Fuelled by misinformation about women's substance use and addiction, and harsh media representations, stigma and judgement are ever-present in women's support networks, service delivery, and program policies. Although there are welcoming and mother-centred programs across Canada, there are vast gaps in the availability and accessibility of these services, depending on the required level of care, mothering status, and the severity of health and social problems.

Due to fears of disclosure and limited data, it is difficult to quantify how many mothers and pregnant women have substance use problems. According to the 2001 Canadian Community Health Survey, 12% to 14% of women reported that they had used alcohol in their last pregnancy. [1] A recent American survey of pregnant women reported that 19% of women used alcohol in their first trimester, 7.8% in their second trimester, and 6.2% in their third trimester. [2] Further, of the women who used alcohol in their first trimester, 8% binge drank, 21.8% smoked cigarettes, and 4.6% used marijuana. [2] Particularly concerning was the rapid resumption in binge drinking from 1% in the third trimester to 10% within three months postpartum. [2]

It is estimated that 18% of mothers engaged with the child welfare system have alcohol problems, and 14% have other substance use problems. [3] It is also documented that First Nations mothers in Canada lose custody of their children more than non-First Nations women; First Nations children are placed in care at a rate of 1 in 10, whereas non-Aboriginal children are placed in care at a rate of 1 in 200. [4]

Given the risks of heavy substance use to both women's and children's health, including the risk of Fetal Alcohol Spectrum Disorder, it is imperative that a continuum of gender-informed services be available to mothers and pregnant women with substance use problems.

Participants in the virtual Community of Practice (vCoP) discussed four topics related to mothers and pregnant women with substance use problems: 1) stigma and public discourse, 2) barriers to treatment, 3) a guiding framework for practice, and 4) examples of Canadian mother-centred programming. An overview of these four topics is presented here, followed by a list of discussion questions and a list of weblinks, both which emerged from this vCoP. The discussion questions are designed to facilitate the application of a gender-based analysis to addictions prevention, harm reduction, and treatment programming and policy as they relate to pregnant women and mothers.

Stigma and public discourse

Stigma surrounding women who are pregnant or mothering and using substances is evident throughout our systems of care and in the public discourse. Historically, and presently, public discourse has been both blaming and unsympathetic towards mothers who use substances. [5] Further, mothers who use substances are deemed solely responsible for their circumstances, and undeserving of care. [6] Despite national efforts to shift this paradigm [7], media continue to misrepresent the needs and intentions of mothers with substance use problems, and propose punitive, over supportive, health-

oriented responses. [8, 9] Consequently, shame and fear of prejudicial treatment based on motherhood status are ever-present, and prevent women with substance use problems from accessing the care that they need and deserve. [10]

Barriers

Barriers for mothers and pregnant women with substance use problems are evident on three levels: systemic, program, and personal/social. [11] At a systems level, barriers are created in punitive mothering policies, fragmented services, and narrow service mandates. The needs of women and children are often polarized, and linked and combined support for the mother-child unit is overlooked. [5] Women repeatedly report that fear of losing their children is one of the most significant barriers to treatment. [10, 12] When women do access treatment, silos of services with narrow mandates can result in women being turned away due to the complexity of their situations; situations that intertwine, for example, substance use in combination with violence and trauma, mental ill health, physical health problems, and housing needs.

At a program level, admission criteria and wait lists are common barriers. For example, some programs require a certain number of days abstinent before a woman is eligible for support. This may not be a realistic criteria given inadequate housing and challenges in meeting basic needs. Wait lists may make it difficult for mothers to retain custody of their children, and the timing of child welfare requirements and substance use treatment services are often out of sync. [13] Other program level barriers include service hours, location (urban vs. rural), and cultural appropriateness.

On a personal level, women may not be supported by their family and peers, and they may be afraid to leave their children in the care of others. In some instances, pregnant women are living with violent partners who do not want them to make changes to their substance use. [14] Until treatment services understand many of the personal and social barriers faced by mothers, and take active steps to reflect this in their service delivery, women will continue to be faced with decisions such as choosing between treatment and caring for their families.

Guiding framework for practice

It is important that practice, programs, and policies be principle-based and firmly grounded in evidence. The guiding framework underlying effective treatment and support for mothers and pregnant women with substance use problems, which gained support in the ActNow BC Healthy Choices in Pregnancy initiative (www.hcip-bc.org), includes being mother/women-centred, harm reduction oriented, and taking a collaborative approach to treatment. [15, 16]

Mother/Women-Centred

Historically, society and health care services have taken a child- or fetus-centred approach in their response to substance exposure in pregnancy, with little regard to the health and well-being of birth mothers. [17] Women-centred care offers an alternative by focusing on the mother-child unit. Emphasis is placed on the woman's own health pre, during, and post-pregnancy and internal motivation for change is supported. Within this framework, the negative social responses to women who are pregnant or mothering and have substance use problems are acknowledged, and service providers assist women in dealing with stigma, punishment, and blame. [18]

Harm reduction oriented

In the context of mothering and pregnancy, reducing the harm of substance use often means attending to women's basic needs such as nutrition and housing. Harm reduction approaches take a pragmatic and compassionate approach to care. Service providers are willing to discuss goals other than complete abstinence from all substances (in spite of the known risks), and consider all aspects of harm. [19] In this approach, there is recognition of the interconnectedness of many areas of women's lives, such as trauma, mental ill health, and substance use. [20, 21] Accordingly, engagement in treatment begins with what is most important and possible for the woman.

Collaborative

Collaboration is a key principle of both women-centred and harm reduction approaches. It is critical to successful relationships with women, and change and healing happen in supportive, non-judgemental, respectful relationships. [22-24] In collaborative approaches, women are viewed as the experts on their own lives and work collaboratively with service providers toward paced, achievable, change.

Motivational interviewing (MI) is an evidence-based communication style that supports engagement and is noted to improve the health of women with substance use problems and related concerns, particularly in the childbearing years. [25-27] MI combines relational components with key skills and strategies [28], thereby guiding change while at the same time supporting collaboration, empowerment, and respect for autonomy.



Examples of Canadian Mother-Centred Programs

While a generic range of treatment services are available to mothers, these services are not always visible or readily accessible. [29] The National Treatment Strategy offers recommendations to strengthen available substance use services and support through five tiers of support and treatment. The tiers are described as:

Tier 5 - Intensive residential treatment

Tier 4 - Structured and specialized outpatient services

Tier 3 - Acute, proactive outreach and harm reduction services

Tier 2 - Brief support and referral by a wide range of professionals

Tier 1 - Community-based and outreach services

(For a more detailed description of the tiers see: www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf)

To successfully address the needs of mothers and pregnant women with substance use problems, we need gender-informed programming and practices that reflect the guiding framework in all 5 tiers of support and treatment. The following Canadian examples demonstrate the types of programming and practices needed at each tier of support and treatment.

Tier 5 – Residential treatment programs

There are very few Canadian examples of residential treatment programs that accommodate mothers with their children. However, in an attempt to address this limitation of services, some jurisdictions are putting in place supportive housing options, with links to residential treatment, for pregnant women prior to delivery, and new mothers and their infants postpartum.

Tier 4 – Structured outpatient services

Jean Tweed Centre, Pathways to Healthy Families and MK2, Toronto, ON

(www.jeantweed.com)

The Pathways to Healthy Families project, initiated in 2002, addresses the need for building capacity within the system to better identify and serve women who use substances who are pregnant or mothering young children. It involves the placement of substance use counsellors in satellite sites across Toronto, including community health centres, resource centres for young parents, the shelter system, and Aboriginal services. These counsellors provide education and support services to women and their children, as well as to agencies. The focus of the support is to connect women with local resources, advocate on their behalf, and link them with parenting and medical care. [30]

Arising out of the Pathways to Healthy Families project, Mothers and Kids Too (MK2) is a specialized outpatient program that addresses the needs of mothers who are pregnant and/or who have children under the age of six. MK2 is a seven week long, three day a week, format that provides both substance abuse counselling and parenting support. In this model, women do not have to choose between their family and treatment. Emphasis is placed on integrating programming for parents and children, ultimately supporting early childhood development and engagement of parents.

Tier 3 – Proactive outreach and harm reduction services

Pregnancy Outreach Programs (Canada Prenatal Nutrition Program)

(www.phac-aspc.gc.ca/dca-dea/programs-mes/cpnp_goals-eng.php)

Community-based pregnancy outreach programs (POP) funded across Canada through the Canada Prenatal Nutrition Program (CPNP) offer drop-in, multi-faceted, prenatal and postnatal programming to support the overall health of mothers and their children. Attending to basic needs such as nutrition, physical health, and safety, POPs work pragmatically to meet women where they are at and to reduce the harms of substance use. In many instances, women with substance use problems may feel safer accessing services through POPs than asking specifically for addiction treatment services and risk losing their children.

There are approximately 350 CPNP projects serving over 2,000 communities across Canada, and over 550 CPNP projects in Inuit and on-reserve First Nation communities.

Tier 2 – Brief support and referral by a wide range of professionals

Brief Intervention by Physicians

Physicians play an important role in both recognizing and engaging mothers and pregnant women with substance use problems, and they play a pivotal role in the prevention of FASD. [31] Given the social stigma and misunderstanding of this health problem, it is critical that health care providers are able to ask about substance use in a supportive and non-judgemental way.

The PRIMA (Pregnancy-Related Issues in the Management of Addictions) project assists physicians in providing care for pregnant and postpartum women with substance use problems through continuing education initiatives and web-based resources on the effects of various substances and clinical considerations (www.addictionpregnancy.ca).

Physician education has been offered nationally through a continuing education course on Fetal Alcohol Spectrum Disorder created by MDcme.ca, a consortium of seventeen Canadian medical schools and the College of Family Physicians of Canada (www.mdcme.ca). This curriculum is currently being updated.

Several provinces have also undertaken educational initiatives with physicians: for example the ActNow BC Healthy Choices in Pregnancy initiative worked with physicians to implement provincial guidelines on screening and discussing alcohol with pregnant women (www.hcip-bc.org/resources-for-practice/physicianresources.htm); and Ontario's Best Start has developed desk references and related tools for physicians (www.beststart.org/resources/alc_reduction/index.html).

Tier 1 – Community-based and outreach services

InSight: Mentor, Support, Empower, Manitoba

(www.gov.mb.ca/healthychild/fasd/insight.html)

The InSight Mentoring Program is a Manitoba-based example of one of a number of peer support mentoring programs evolving across Canada. It is a voluntary intensive case management program that provides service to women who are pregnant or recently gave birth, and have used alcohol and/or drugs heavily. Mentors provide intensive one-to-one support for women and their families for up to 3 years. The focus is on reducing barriers and building safe, collaborative relationships that empower women in making paced, achievable, changes.

Discussion questions

The following questions are intended to support direct-service providers, program leaders, and system planners in reflection on their current practices, policies, and procedures.

1. What have you noticed about how mothers and pregnant women with substance use problems are treated within the health and social service system? What do you notice about your own reactions?

2. Consider your program, practice, and/or policies from the perspective of a mother with a substance use problem who needs help. How will you be welcomed? What sort of questions will you be asked? How will it feel talking with a service provider who potentially has the power to impact your ability to mother (i.e., remove custody of your children)? What would make this safer?

3. What can you do in your role to shift media and societal perceptions of mothers and pregnant women with substance use problems?

4. How is your program linking with other agencies in a position to support women's health and reduce harms related to substance use? How is your program supporting women to connect within their communities?

5. What can be done to improve the relationship with the child welfare system to best support the mother-child unit?

6. What steps are being taken to integrate childcare services with current programming?

7. What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability? How are the outcomes being measured?

8. How are mothers and pregnant women with substance use problems involved in influencing program development specific to your service?

Weblinks

National

Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives (Public Health Agency of Canada)
www.phac-aspc.gc.ca/fasd-etcaf/cp-pc-eng.php
This document describes a four-part model for approaching Fetal Alcohol Spectrum Disorder prevention from a women's health perspective. It is a practical resource that shares the wisdom of program providers across Canada and offers examples of promising practices in action.

Motherisk
www.motherisk.org
Motherisk offers information and counselling to pregnant and breastfeeding women, their families, and service providers, on a number of topics, such as the impact of licit and illicit substance use in pregnancy. The website hosts a variety of written materials and lists toll-free helplines, including the Alcohol and Substance Use Helpline for information about the fetal effects of alcohol, nicotine, and drugs like marijuana, cocaine, and ecstasy (1.877.327.4636).

Provincial

Alberta Health Services, AADAC Effects Series
www.aadac.com/547_1430.asp
This series is designed to give women specific information about the health effects of various drugs, with a special focus on how drug use may affect pregnancy, birth, and child development. The information is presented in a non-threatening, women-centred way moving from the health of the mother to the health of the fetus.

Best Start
www.beststart.org
This Ontario-based resource centre has developed a variety of materials and tools to support service providers working on health promotion initiatives to improve the overall health of women and their children. Print resources are available for order on topics such as pre-conception health, alcohol and pregnancy, and post-partum depression.

Coalescing on Women and Substance Use
www.coalescing-vc.org
This website highlights online "virtual" discussions on six key topics related to women's substance use in Canada including mothering and substance use, and the prevention of Fetal Alcohol Spectrum Disorder. The site also offers a number of helpful information sheets highlighting key points and resources related to each of the six topics.

Healthy Choices in Pregnancy
www.hcip-bc.org
This website hosts a number of resources to support service providers, researchers, and system planners in their work related to women and alcohol and related health issues. Recent publications, past presentations, webcast recordings, and resources for women around the health impacts of alcohol are all available on this site.

Summary

This discussion guide was prepared to assist individuals and agencies working on the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances* with the application of gender-based analysis. Hopefully it will be a useful resource in the development of "gender-informed" prevention programming, harm reduction initiatives and treatment directed to mothers and pregnant women, by those working on the Framework, and by others interested in improving policy and practice related to substance use and addiction in Canada.

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British Columbia Centre of Excellence for Women's Health
E311 - 4500 Oak Street, Box 48
Vancouver, British Columbia V6H 3N1
Canada

Email: bccewh@cw.bc.ca

Download this document at:
www.coalescing-vc.org

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Women-Centred Harm Reduction

In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a "virtual discussion" of issues, research, and programming related to girls' and women's substance use in Canada. The goal of the vCoP was to serve as a mechanism for "gendering" the National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP. Its purpose is to stimulate further conversation on gendered approaches to harm reduction.



Gendering the National Framework



Background

Harm reduction approaches to substance use have been a part of Canadian preventionand management efforts for many years. [1] The emphasis has been on decreasing individual harm from problematic substance use through the provision of specific policies and services (e.g., supervised injection facility). However, participants in the vCoP noted that the broader determinants of women's health—such as, poverty, mothering, violence, and social policies—are not well enough accounted for in the design of harm reduction strategies. In order to increase the effectiveness of these strategies, it is pertinent to introduce a gender lens to harm reduction initiatives. In the context of women's substance use, harm reduction cannot simply be about the intersection of one health determinant with the use of substances; it is instead about how many health determinants interact, and in turn amplify or influence the experience of women's substance use.

Harm reduction strategies are commonly discussed from the perspective of the policies and service continuum needed to assist illicit drug users, however, this discussion guide will use a gender-based analysis, including a determinants of health lens, to explore reducing harms associated with women's licit and illicit drug use. While not all encompassing, this resource offers a place to start the discussion on how to bring a gender-based analysis to harm reduction strategies. This discussion guide will briefly introduce some of the intersecting components of harm reduction and health determinants, highlighting the key ways that these elements interact to influence women's health and women's substance use experiences, followed by a list of weblinks and discussion questions. The discussion questions are designed to facilitate the application of a gender-based analysis to addictions prevention, harm reduction, and treatment programming and policy.

Reducing harms across social determinants of women's health

The following sections briefly illustrate and explore the intersection of determinants of women's health, providing highlights of current research and practices that exemplify this perspective related to:

- violence and trauma
- pregnancy and mothering
- criminalized women
- sex work
- housing
- HIV/AIDS

Through these descriptions, it can be seen how understanding harm reduction from a gendered perspective is critical to successfully attending to the needs of women who use substances, and to advancing the effectiveness of harm reduction programming.

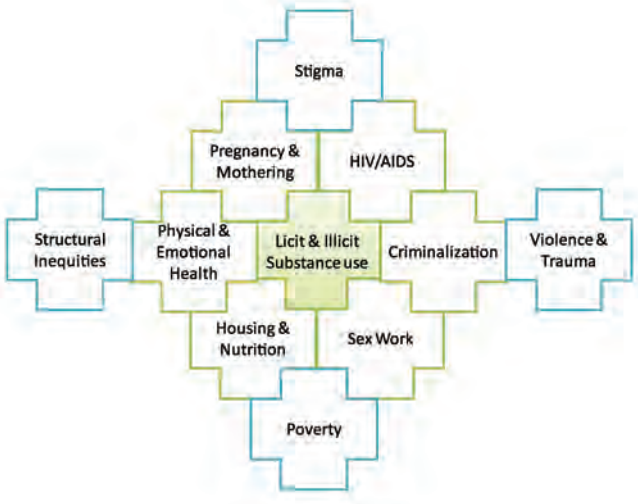
Violence, licit and illicit substance use

Girls' and women's experiences of sexual abuse, interpersonal violence, and other forms of gender-based violence are central to their use of substances. [2]

Women drug users are more likely than their male counterparts to experience sexual violence, and other forms of violence. [3, 4] Additionally, substance-using women are more likely than substance-using men to die prematurely due to violence. [5, 6] In Vancouver's Downtown Eastside—an area renowned for high levels of illicit substance use—over 60 women have been reported missing or murdered in the past two decades. A study conducted in this area of Vancouver found that street-level sex workers were deterred from accessing health, social, and syringe exchange services, because of their need to avoid the physical environments where these services were located, where they were exposed to violence and policing. [7]

Increasing attention is being brought to the interrelationships between historical trauma, continuing or everyday violence, poverty, and structural inequities created by these realities, which affect women's access to integrated and effective health services. [8, 9] Structural inequities in access to services hold true for women who use both licit drugs as well. For example, women who have experienced violence are often prescribed prescription drugs with addictive potential for longer than recommended periods and find minimal support for tapering off these drugs and accessing other forms of support. [10, 11] This exemplifies the need for integrated services that account for gendered harms linked to substance use.

Clearly, in order to address the concerns emerging from the many interacting aspects of violence, trauma, and substance use, harm-reducing systems of care need to be characterized by connections across and among services. Linking between services such as: domestic violence and sexual assault prevention and recovery programs, supports for residential school survivors, sexual and reproductive health services, STI prevention services, supportive primary care, addictions services, housing, legal aid systems, and so forth, would allow for more effective harm reduction programming.



Pregnancy and mothering

Pregnancy, mothering, substance use, and social stigma interact to influence the accessibility of healthcare for women.

Highly negative views of women's substance use deter pregnant women and mothers who use substances from accessing health-related and social services for fear of being judged, treated poorly, and losing custody of their children. [12-15] As a result, the opportunity to respond to women's need for connection, discussion of substance use, prenatal care, overall health care, practical supports, methadone treatment, and other harm reduction strategies are forestalled. These types of information and support, which can improve the birth outcomes of women's children, as well as their own health, are therefore missed. [16]

However, there are cases where gendered harm reduction strategies are being implemented. Non-judgmental, comprehensive outreach programming for pregnant women is now being delivered as a best practice in Toronto, Edmonton, Calgary, Vancouver, Hamilton and many other locations across Canada. [17-20] Key maternity care services are also shifting their service paradigms to assist women to reduce harms associated with illicit drug use in pregnancy and to retain custody of their children postpartum. [21] Mothers are becoming actively involved in identifying strategies for reducing harms associated with their substance use. For example, mothers were involved in developing the Start Thinking About Reducing Second Hand Smoke program. [22]

Despite some advances, particularly in the promotion of harm reducing approaches for pregnant women with alcohol problems, we have a long way to go. To improve the accessibility of harm reduction programming, and reduce gendered harms to women who use substances and their children, we need to counter harsh media representations, eliminate rigid abstinence-only service policies, and address ill formed and punitive drug policy and child welfare policy affecting pregnant women and mothers who use drugs. [23, 24]



Criminalized women

For criminalized women, substance use, mothering capacity, financial insecurity, physical health and emotional health challenges, and for some the impacts of incarceration interact and compound each other.

Criminalized women are most likely to be incarcerated for property crimes such as shoplifting, theft, and robbery [25], crimes that are related to poverty and substance use. Incarcerated women in Canada have high rates of physical health, mental health, literacy, and substance use problems. [26] And yet historically, prison and correctional centre harm-reduction programming related to these overall health concerns has been limited. [27-30] Additionally, approximately two-thirds of Canadian female inmates aged 19–34 years are mothers of children younger than five-years-old. [31] It has been estimated that 25,000 Canadian children are impacted by their mothers' incarceration each year. [32] A range of harms from feelings of guilt and depression, increased use of alcohol and drugs, increased criminal activity, and re-incarceration are associated with separation of criminalized mothers and their children. [33] Aboriginal women are most affected by all the harms related to criminalization, as there is a disproportional representation of Aboriginal women incarcerated in Canada. [34]

Given the strong interaction of health determinants and gendered harms for criminalized women, some agencies are responding with women-centred harm reduction programming and research initiatives. For example, agencies such as the Elizabeth Fry Society are helping community-based and correctional services understand criminalized women's self harm, and are identifying trauma-informed, harm reducing ways of supporting women. [35] Aboriginal women in conflict with the law are also becoming involved in defining their needs for support on substance use issues (highlighting the importance of connection to culture, healing from trauma, and motherhood issues). [36] Criminalized women are also engaging in empowering research projects that define their healing and health service needs within the prison context, shedding further light on what effective gendered harm reduction programming might address. [37-39]

Sex work

Sex workers face significant harms related to the dangers of street work. [40, 41] Harms range from the risk of HIV acquisition, to experiencing discrimination, to conflicts with the law, to being exposed to violence. [42, 43] Yet it can be difficult for sex workers to access information and harm reduction services. [27] The stigma associated with both sex work and substance use operates to affect sex worker's health and limit their access to health care and other supports. [44-46]

Cusick [47] identified the need to broaden the harm reduction agenda from a focus on drugs specifically , to include promoting health among sex workers. She and others emphasize that in the case of sex workers, harm reduction

must examine ways of reducing inequities and challenges associated with entering and exiting sex work. [48, 49] For example, in a study in 2002, a study showed that less than half of the street-level sex workers entered sex work to support an existing drug habit. [50] Rather, they were propelled into street-level sex work by financial need. This finding was confirmed in recent research by a Canadian coalition of sex workers. [48]

In an attempt to address the intersecting needs of sex workers, and mitigate associated harms, the Mobile Access Project (MAP) in Vancouver, BC, serves as a mobile drop-in center for sex workers on the street. The mobile drop-in centre offers a place where women can report "bad dates," receive resource information and referrals, peer counselling, free condoms, clean needles, emergency medical care, and a safe respite. [51] By offering these services in a manner that is accessible and responsive to women sex workers' immediate needs, MAP exemplifies women-centred harm reduction strategies.

Housing

Often homeless girls and women are not visible in ways similar to homeless boys and men, as they are 'under-housed' versus living on the street. [52, 53] As such, their housing needs are often overlooked in harm reduction strategies. This is problematic, as unstable housing conditions are associated with poorer physical health, mental disabilities, fewer social supports, minimal education, traumatic histories, and little employment history, as well as vulnerability to HIV contraction, alcohol and drug use, and victimization. [54-56] Homeless women are at high-risk for sexual assault. [57] Gender-informed harm reduction strategies acknowledge that adequate housing for women and children is essential to mitigating harms and improving health.

Homeless and domestic violence shelters are part of a continuum of housing needs for women who use licit and illicit drugs. [58] In BC, the Atira Women's Resource Society offers multiple levels of transition/housing supports for women at various stages of homelessness and recovery from mental health and substance use problems. Sheway, a program for substance using mothers in downtown Vancouver, has shed light on how even a minimal addition of financial support over short periods of time can help mothers secure adequate housing, which in turn reduces a range of harms, and often allows women to retain custody of their children. [59]

HIV/AIDS

Decades into the AIDS pandemic, women are disproportionately impacted by HIV infection. [6] A range of health determinants—including physical, social, economic, and public policy dynamics—interact to put women at risk of HIV infection.

A study of women who were HIV+ in Vancouver's Downtown Eastside showed high uptake of health and social services, yet limited attention to HIV care, with only 9% of the women on antiretroviral therapy (HAART). [60] In this case, self-reported barriers to accessing treatment were largely attributed to misinformation and misconceptions about treatment. Speaking more broadly, issues surrounding HIV prevention and treatment for women have been summarized by the Vancouver based Positive Women's Network as follows: 1) no prevention method that women can control without cooperation of her sexual partner; 2) acute biological vulnerability to infection during unprotected heterosexual intercourse (while treatments are still mainly tested on men); 3) controlling partners who limit safer sex, access to health care, support, and financial resources; 4) social expectation to be caregiver to immediate and extended family members limits women's self-care opportunities; 5) unequal economic power; and, 6) the repercussions of disclosure can equal disaster for women, their children, and their safety. [61] Issues related to pregnancy and mothering are also relevant to reducing harms related to HIV – women who are HIV+ need to be able to access non-judgmental medical care to receive ARV medication which prevents in utero transmission of HIV, medication which is nearly 100% effective if pregnant women with HIV are supported in taking them. [62, 63]

A participatory action research project involving women who use drugs in Vancouver has documented the health inequities and barriers to accessing a wide range of services—including primary health care, and harm reduction services. The research resulted in recommendations for opportunities to improve policy and practice to enhance quality and continuity of primary care for women who use drugs. [64] This study exemplifies core principles of harm reduction and women-centred care – that women/drug users definitions of their needs need to be respected, that human rights to healthcare need to be honoured, and that efforts to make care safe and empowering for women are important. [1, 65]

Examples of women-centred harm reduction

Provided below are examples of women-centred harm reduction programs that offer a scope of services intended to respond to intersecting determinants of women's health.

Atira Women's Resource Society

(www.atira.bc.ca/housing.html)
Atira demonstrates women-centred harm reduction in action. Atira Women's Resource Society is a community-based organization that supports all women, and their children, who are experiencing the impact of violence committed against them and/or their children. Atira's approach is multi-faceted including housing, advocacy, education and support. Combining staged housing, from emergency to long-term, with women-centred services such as 16-step groups and wrap-around support. Atira offers a variety of services for pregnant and parenting women through the Maxxine Wright Community Health Centre, including pre and post-natal medical care, substance use counselling, safety planning as well as food programs and many other services. Emphasis is placed on providing comprehensive women-centred care and wrapping support around women and their children.

Fir Square Combined Care Unit

(www.bcwomens.ca/Services/PregnancyBirthNewborns/HospitalCare/SubstanceUsePregnancy.htm)
The first in Canada to provide care for substance using women and their substance-exposed newborns in a combined unit (mothers and babies room-in together), the Fir Square program provides non-judgmental assessment, detoxification, care and support to substance using pregnant women. Guided by a harm reduction philosophy, the overall aims of the program are to help reduce substance use and related risks, to help women gain confidence with parenting and, ultimately, to support mothers and their babies to safely stay together after they leave hospital. The program meets the needs of women through collaboration with community groups and with child welfare services, as well as through the provision of addiction services, and education about infant development.

Wish Drop-in Centre Society

(www.wish-vancouver.net/index.cfm)
The Wish Drop-in Centre provides services for women in sex work, or seeking to exit sex work, in a non-judgmental, nurturing environment. In addition to providing essential needs, such as nursing care, hot meals, showers and clothing, Wish provides referrals to substance use treatment, rehabilitation housing, and shelters. Opportunities to alternative lifestyles are supported by the Wish Literacy and Learning Centre. Wish also partners with other groups to provide opportunities for research and services, including the Mobile Access Project, a mobile drop-in center for sex workers on the street. (www.wish-vancouver.net/index.cfm?go=site.index&section=programs&page=map)

Community-Based Research with Criminalized Aboriginal Women

(www.addictionresearchchair.com/creating-knowledge/national/cihr-research-project/)
This study is a community-based collaborative research project between the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse and the University of Saskatchewan. The project examined the role that identity and stigma have in the healing journeys of criminalized Aboriginal women in treatment for illicit drug use. In efforts to share the findings of the research, a powerful music video called From Stilettos to Moccasins was released giving voice to Aboriginal women healing from drug abuse, addictions and problems with the law, together with those who are helping them on their journey (www.youtube.com/watch?v=1QRb8wA2iHs). Hopefully, through a better understanding of the experience of criminalized Aboriginal women, treatment services can be improved to meet their needs and the needs of the community overall.



Moving Forward

Clearly the territory of reducing harms related to women's substance use, and related health and social concerns is inviting action. The way in which women's health determinants act and interact need to be taken into account in all we do; the damaging effects of the intersections between poverty, experience of violence, racism, gendered patterns of drug use/harms, and lack of support for mothering are critical to address. We are beginning to acknowledge how a combination of work on structural interventions in legal and policy arenas, physical and social environmental changes such as access to safer sex work and supportive housing, improved support through a seamless service network, as well as support for peer driven action will be important.

Discussion Questions

The following questions are intended to support direct-service providers, program leaders, and system planners in reflection on their current practices, policies, and procedures.

1. What have you noticed about the links between poverty, mothering, substance use and violence? How might these interconnections impact the care a woman receives?
2. Consider your understanding of harm reduction. In what way, if any, has the information in this discussion guide influenced your understanding?
3. How might your program link with other women-centred harm reduction programs?
4. How is the role of trauma understood in your service? How does this translate into policies and program development?
5. If a pregnant woman with substance use problems were to describe her initial interaction with your program, what might she say? How would she feel? What might be some of the barriers to receiving care? What are the strengths of your service that would encourage her to come back?
6. How does your service work to address some of the stigma and barriers women face in accessing services? Are there specific needs to be addressed for pregnant women? What about for women in conflict with the law?
7. Why is it important to shift from a continuum of harm reduction services lens, to a determinants of health lens? How might this impact your program/policies? How does this involve the greater community?
8. What training is available to support service providers in using a gender-informed harm reduction approach?

Weblinks

Peer Support

Women's Harm Reduction International Network (WHRIN)
www.talkingdrugs.org/womens-harm-reduction-group
The WHRIN works to create and maintain an international network for women and those working with them who are engaged in HR in order to share resources, disseminate materials, provide a forum for discussion and a basis for advocacy and training.

Housing

The Street Health Report – Women and Homelessness
www.streethealth.ca/Downloads/SHResearchBulletin-2.pdf
This bulletin provides a comprehensive overview of the physical and mental health, well-being, access to health care, and daily realities of homeless women in Toronto.

Coming Together: Homeless women, housing and social support
www.comingtogether.ca
The website describes an arts-based community research project exploring how women and transwomen who are marginally housed in Toronto built support networks with each other in order to survive.

HIV/AIDS

Positive Women's Survival Kit (International Community of Women Living with HIV/AIDS)
www.icw.org/files/Survival%20Kit.pdf
This education resource is based on the shared experiences of women living with HIV around the world. A range of topics are covered including pregnancy and mothering, relationships, sex work and women in prison.

Integrating gender into HIV/AIDS programmes
www.who.int/gender/hiv_aids/en/Integrating%5B258KB%5D.pdf
This tool helps programme managers and health-care providers in the public and private sectors integrate gender into HIV/AIDS programmes they wish to set up, implement and evaluate so they are more responsive to women's needs.

Sex Work

Wish Drop in Centre Society
www.wish-vancouver.net/index.cfm?go=site.index&section=about&page=mission
To increase the health, safety and well-being of women working in the sex trade in Vancouver's Downtown Eastside, WISH provides a range of services and supports and engages in advocacy, community education, and relationship building.

Sex Professionals of Canada (SPOC)
www.spoc.ca
The SPOC provides information about legal, health and advocacy issues surrounding sex work and sex workers rights.

Pregnancy and Mothering

National Advocates for Pregnant Women
http://advocatesforpregnantwomen.org/
The US based National Advocates for Pregnant Women (NAPW) seeks to protect the rights and dignity of pregnant and parenting women, and those who are most vulnerable including low income women, women of color, and drug-using women —through involvement in court challenges to punitive reproductive health and drug policies and public education efforts.

A Visceral Grief: Young Homeless Mothers and Loss of Child Custody
www.urbancentre.utoronto.ca/pdfs/researchbulletins/CUCSRB34Novacetal.pdf
This research paper from the Centre for Urban and Community Studies describes the experience of young homeless mothers who lose custody of their child and the service interventions available to the mothers.

Criminalized Women

Caught in the Net
www.aclu.org/drug-law-reform/caught-net-impact-drug-policies-women-and-families
This US report advocates for drug laws and policies that adequately take into account the needs of women and their families, and address the root causes of women's involvement with illegal drugs.

Girls and Young Women

It's a Girl Thang! A Manual on Creating Girls Groups
www.mcs.bc.ca/pdf/its_a_girl_thang.pdf
This Canadian resource presents an innovative girls group program model which uses a relational/cultural framework to guide the prevention and intervention of at risk and marginalized girls. Girls were invited to share their experiences and help shape the manual.

What's your problem? – Claymation project
www.youtube.com/watch?v=HSPedmfqR5U
Researchers and support workers collaborated with an Aboriginal Girls Group in Chase, BC to create this claymation project with a message around date rape and alcohol.

Summary

This discussion guide was prepared to assist individuals and agencies working on the National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances with the application of gender-based analysis. Hopefully it will be a useful resource in the development of "gender-informed" harm reduction initiatives by those working on the Framework, and by others interested in improving policy and practice related to substance use and addiction in Canada.

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British Columbia Centre of Excellence for Women's Health
E311 - 4500 Oak Street, Box 48
Vancouver, British Columbia V6H 3N1
Canada

Email: bccewh@cw.bc.ca

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