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Intimate Partner Violence, Mental Health Services and the COVID-19 Pandemic in Ontario: What are the differences, if any, in mental health service accessibility and service satisfaction during COVID-19 between women in abusive relationships and women in non-abusive relationships?

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Abstract

Introduction: Intimate partner violence (IPV) increased during the COVID-19 pandemic in Canada as a result of increased economic pressures and social isolation brought on by stay-at home orders. During the COVID-19 pandemic, women experiencing IPV experienced declines in mental health conditions and unique difficulties in accessing mental health services amid closures, shifts in service delivery, and inconsistent availabilities.

Methods: An online survey was administered to 44 women living in Ontario (23 who had not experienced IPV and 16 who had not) to explore their satisfaction and access to mental health services during the COVID-19 pandemic. Descriptive statistics were used to explore differences in access and satisfaction between those who had experienced IPV and. Those who had not. An inductive thematic analysis was used to understand the types of barriers being faced by women.

Results: Women who experienced violence had higher means for satisfaction and demonstrated lower barriers of access. Women indicated using a range of mental health services with primary health care providers and pharmacies being used more frequently. The main barriers to access faced by women were waitlist challenges and the limited availability of healthcare. professionals.

Conclusion: This study highlights the nuances of access and satisfaction while capturing the need for multi-sectoral collaboration in ensuring that women know which services are available to them during global crises. Further research is required to explore the satisfaction and access of women experiencing IPV with specific mental health services.

Keywords: intimate partner violence, COVID-19 pandemic, mental health services, gender-based violence, health service utilization

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Summary for Lay Audience

Introduction: There was an increase in intimate partner violence (IPV) during the COVID-19 pandemic in Canada and globally. IPV is the most common form of GBV and is understood as physical, sexual, and/or emotional abuse in the context of coercive control perpetrated by an intimate partner. The need for ongoing access to timely mental health services has been established as a priority before the COVID-19 pandemic for women experiencing IPV. However, during the COVID-19 pandemic while access to all services was disrupted, mental health services were of particular importance given the well-established isolation and associated mental health consequences of the public health guidelines and the increases in IPV. Current research focuses on the experiences of service providers and the operational challenges of delivering accessible and effective mental health services to women experiencing violence during the COVID-19 pandemic; however, what is missing is the voice of women.

Methods: An online survey was administered to 44 women living in Ontario (23 who had not experienced IPV and 16 who had not) to explore their satisfaction and access to mental health services during the COVID-19 pandemic. Trends were used to explore differences in access and satisfaction of mental health services between those who had experienced IPV and those who had not. Responses on the types of barriers being faced by women were grouped into themes.

Results: Women who experienced violence had higher means for satisfaction and demonstrated lower barriers of access. However, the study uncovered the main barriers of access and being wait times and lack of availability of health-care professionals.

Conclusion: Overall, this study highlights the unique experiences in access and satisfaction with mental health services for women experiencing IPV while capturing the need for multi-sectoral collaboration in ensuring that women know which services are available to them

during global crises. Further research is required to explore the satisfaction and access of women experiencing IPV with specific mental health services.

Dedication

Rest in peace Uncle Prince, until we meet again.

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1 Chapter 1

1.1 Introduction

Gender-based violence (GBV), rooted in harmful norms and abuses of power, is any act of violence perpetrated because of someone's gender identity (World Health Organization, 2021). Gender-based violence can include physical, sexual, psychological, and/or financial abuse (World Health Organization, 2021). Gender-based violence is a human rights violation with many and varied short and long-term health, economic, and social consequences (Heise, 1998).

Intimate partner violence (IPV) is the most common form of GBV and is understood as physical, sexual, and/or emotional abuse in the context of coercive control perpetrated by an intimate partner (S. R. Montesanti, 2015; TJADEN & THOENNES, 2000). Intimate partner violence has been well-established as a significant public health concern that globally impacts one in three women in their lifetime (World Health Organization, 2021). Although any woman can experience IPV, it is most commonly experienced by women 15 to 24 years of age with 29 percent of women reporting experiencing IPV at least once during this time frame (Cotter, 2021). This is double the proportion of violence reported among women between the ages of 25 to 44 years (Cotter, 2021). Further, it is estimated that globally 70 percent of women will experience violence at some point in their lifetime (Unicef, 2014), underscoring the magnitude of the GBV endemic (Sorenson et al., 2021).

The health consequences of IPV are numerous, occurring both during and beyond the end of the intimate relationship (Ford-Gilboe et al., 2020). Depression and post-traumatic stress disorder are the most common mental health sequela associated with experiencing IPV, as women with experiences of violence are 3 to 5 times more likely to have symptoms consistent with depression and post-traumatic stress disorder compared to women who have not experienced violence (Dutton et al., 2006). Common physical health consequences of IPV include bruises, minor cuts, punctures, chronic pain, and hearing loss (Ali et al., 2021). The most severe consequence of IPV is femicide, the

killing of women and girls on account of their gender (Dawson, 2018). It is important to note that globally, of all murdered women, 35 percent were killed by intimate partners (World Health Organization, 2021). Further, in Canada, the number of women and girls killed by violence has increased from 118 in 2019, to 173 in 2021, a statistic which includes those killed because of intimate partner violence (Canadian Femicide observatory for Justice and Accountability, 2020). Together the health consequences of violence position GBV as a significant public health concern (Sanjel, 2013).

During times of collective trauma and crises, the incidence and prevalence of IPV are known to increase (Jenkins & Phillips, 2008). The ongoing COVID-19 pandemic was no exception with IPV increasing from 40 percent to 100 percent in some countries (Bradbury-Jones & Isham, 2020; vora et al., 2020). Researchers have posited governmental response to the COVID-19 pandemic including stay-at-home orders and physical distancing guidelines, while necessary to slow the spread of this deadly disease, contributed to the increased abuse women experienced during the pandemic compared to pre-pandemic times (Aguero, 2021; Douglas et al., 2020). Gathering Canadian-specific data on increases in IPV during COVID-19 was difficult due to the implications of the rapidly changing nature of the COVID-19 pandemic on collecting real-time data (Michaelsen et al., 2022). However, during COVID-19 one indicator of the increased experiences of IPV was the increase in violence support including IPV support services, crisis lines, and violence reports. Specifically, during the first few months of the COVID-19 pandemic, the use of IPV support services in Vancouver tripled, crisis lines in Alberta saw a 30 percent to 50 percent increase in calls, while IPV and sexual assault reports increased by 22 percent in Ontario (Bradley et al., 2020). While these increases are alarming, it is important to realize they are likely under-reported, for the same reasons historically IPV is underreported, due to shame experienced by women who have faced abuse and privacy concerns (McCleary-Sills et al., 2016). Further, these numbers are also likely underreported for COVID-19-specific reasons including service disruption which made it difficult if not impossible for women to access services during the pandemic as well as accessibility issues, specifically women not being able to access services due to increased surveillance by their partners (Lyons & Brewer, 2021).

While these increases in service use are alarming, it is important to consider the disruptions in services during the COVID-19 pandemic and the impact on those experiencing IPV. During the COVID-19 pandemic, many services were closed and/or shifted to online mediums for delivery (Emezue, 2020). One area of service disruption that is particularly concerning for women is mental health services. The need for ongoing access to timely mental health services has been established as a priority before the COVID-19 pandemic (Sullivan & Goodman, 2019). However, during the COVID-19 pandemic while access to all services was disrupted, mental health services were of particular importance given the well-established isolation and associated mental health consequences of the public health guidelines (Gadermann et al., 2021). The need for access to mental health services was of further importance to equity-deserving groups, such as those experiencing IPV given the common mental health consequences of violence. Before the pandemic, the lack of accessible mental health services for women with histories of IPV has been well-established in the literature and is likely in part due to stigma associated with mental health (Overstreet & Quinn, 2016). During the pandemic, calls to the Vancouver Battered Women Support Services, an IPV service organization that also provides counselling support, tripled whilst some crisis lines experienced 30-50 percent increases in incoming calls (Bradley et al., 2020; Vancouver Battered Women Support Services, 2019). However, not all mental health services were available during the pandemic for women experiencing violence and are meriting further investigation.

2 Chapter 2

2.1 Literature Review

Both the incidence and severity of IPV during the COVID-19 pandemic increased compared to pre-pandemic (Lyons & Brewer, 2021). Emergent evidence has established that the mental health of all people declined during the COVID-19 pandemic as a result

of the stay-at-home public health guidelines (Zajacova et al., 2020). This is especially critical for women experiencing IPV given their existing vulnerability to mental health challenges associated with the consequences of violence (Valera et al., 2022). Increases in IPV as a by-product of COVID-19 public health guidelines coupled with disruptions in service delivery left women experiencing IPV with limited options for services including mental health services at a time of crisis. The purpose of this literature review was to explore the intersection of IPV, the COVID-19 pandemic, and mental health services.

This chapter describes a review of the literature exploring the intersection of IPV, the COVID-19 pandemic, and mental health services. This literature review is divided into 5 thematic sections: 1) increased stress and IPV during the COVID-19 pandemic; (2) IPV and mental health services; (3) mental health services during the COVID-19 pandemic; (4) innovation in service delivery; and (5) barriers to mental health services for women experiencing IPV during the COVID-19 pandemic.

2.2 Increased Stress and IPV During COVID-19 Pandemic

Stress was heightened during the COVID-19 pandemic as a result of the pandemic itself as well as the economic and social consequences of the pandemic. Living through a pandemic has been associated with increased stress as it is a time of trauma and crises (Zajacova et al., 2020). This trauma is further amplified by the economic consequences of the pandemic including unemployment, In March 2020, the Canadian federal government reported an increase of 2.2% in unemployment (Statistics Canada, 2020). Just before the pandemic, Canada's unemployment rate was 5.6 percent, whereas, during the second quarter of 2020, the unemployment rate rose to 15 percent (Larue, 2020). Socially, the COVID-19 pandemic was marked by isolation as a result of the public health guidelines. This isolation resulted in increased stress for many people with a cross-sectional Canadian study reporting an increased amount of stress and anxiety in people under the age of 25 (Nwachukwu et al., 2020). While this heightened stress impacted all Canadians, it is postulated that the rise in stress from economic and social challenges as a result of

the COVID-19 pandemic was a catalyst for increased abuse/severity of abuse as it led to feelings of loss of control by abusers (Collins, Francis, 2020; Walters, 2020).

2.3 IPV and Mental Health Services

Women experiencing IPV need access to effective mental health care which has been described as health care that is trauma and violence-informed, supports social service navigation, and incorporates advocacy into practice (Sorrentino et al., 2021). Trauma and violence-informed service delivery recognizes the ongoing impact of systemic violence and trauma and prioritizes physical, emotional, and cultural safety, person-centred connection, and skill-building amongst affected communities (Ghandour et al., 2015; Wathen & Mantler, 2022). This approach is specifically important in mental health service provision as it ensures that women who have experienced IPV are receiving appropriate and relevant care that meets their needs (Wilson et al., 2015). A trauma and violence-informed perspective on mental health care ensures that experiences of interpersonal violence are explicitly linked to an individual's ability to access services (Wathen & Mantler, 2022). Mental health services range from pharmacotherapy and psychotherapy delivered in acute care and/or community-based settings designed to support survivors' mental health (Leichsenring et al., 2022). According to a Canada-wide consultation conducted by the Ministry of Women and Gender Equality, IPV service organizations in Canada reported a 20 percent to 30 percent increase in calls in early 2020, suggesting women experiencing violence were seeking increased support during the pandemic (Canada Labour Congress, 2020). However, some services, in particular service providers in rural areas, reported significant declines in service use (Moffitt et al., 2022). Researchers have posited this decline was due to women either not knowing services were open or the prolonged proximity to abusive partners meant it was unsafe to engage with services (Canada Labour Congress, 2020). While these increases in service use have been explored thus far in the pandemic through rapid reviews and commentaries, what is missing from research to date is service use experiences from the perspectives of women experiencing IPV during the COVID-19 pandemic (McNeil et al., 2023; Ragavan et al., 2020).

Mental health services play a vital role in the lives of women who are experiencing or have experienced IPV. A Canadian community-based organization reported women who have recently separated from an abusive partner actively sought services to improve their quality of life (Ford-Gilboe et al., 2015). In this study, 43 percent of women sought a mental health service, and among those peer support groups were most used (Ford-Gilboe et al., 2015). Other professional services were also used including psychiatrists (8 percent) and psychologists (11 percent); however, interestingly these services also represented the greatest unmet need for women who were unable to access the service (Ford-Gilboe et al., 2015). Furthermore, this study ascertained that women experiencing IPV use services at notably higher rates than the general population, which was indicative that services being accessed were not always meeting women's needs (Ford-Gilboe et al., 2015). This study reported structural barriers as the primary reason for the low service rates for mental health services (Ford-Gilboe et al., 2015). These gaps in mental health service care highlight the need for trauma and violence-informed care that addresses the ongoing impact of systemic violence on access to health services for women who have experienced violence (Wathen & Mantler, 2022). Further study is required to better explore the roots of these unmet needs to inform the effective delivery of quality mental health service care to this equity deserving population.

2.4 Mental Health Services During the COVID-19 Pandemic

Changes in Mental Health Services Usage During Covid-19

During the COVID-19 pandemic, there were many changes reported in mental health services usage. Particularly hotline and police services reported increased use, physical services changed to meet public health guidelines and the intersection of race and mental health services impacted service use. Each of these will be discussed in turn.

2.4.1.1 Hotline and police services

The COVID-19 pandemic exacerbated existing health inequities, meaning that populations already experiencing poorer health outcomes were further disadvantaged by circumstances resulting from the COVID-19 pandemic (Public Health Ontario, 2020).

During the COVID-19 pandemic, there was a 30 percent decline in rates of mental health-related hospitalizations in Ontario compared to pre-pandemic rates (Natasha R. Saunders et al., 2021). This is concerning given the well-documented increased risk of social isolation experienced during the pandemic (Natasha R. Saunders et al., 2021). A study of 4,587 domestic violence hotline calls in the United States of America (USA) during the COVID-19 pandemic, revealed a decrease in incoming calls immediately after school closures and physical distancing announcements. Sorenson and colleagues (2021) purported that increased social isolation made it difficult for women experiencing IPV to access violence-related services (i.e., domestic violence hotlines, domestic violence calls to police, etc.) (Sorenson et al., 2021). Contrarily, a prospective cohort study conducted in Norway investigated the frequency of IPV calls to the police during a COVID-19 stay-at-home order and found a 54 percent increase in IPV-related calls to the police during the pandemic (Nesset et al., 2021). Divergent findings in the patterns of IPV service use may be attributed to changes to public health guidelines during the pandemic (i.e., times of stay-at-home orders, vs. no stay-at-home orders) making it difficult to access reliable data in real-time (Nesset et al., 2021). It's important to note the differences between countries underscore the importance of varying contextual factors including cultural dynamics. Taken together, evidence from hotlines and police services demonstrate the increase in help-seeking behaviours for those experiencing IPV and the increased risks of hotline usage as a result of physical distancing guidelines during the COVID-19 pandemic.

2.4.1.2 Physical Services

Beyond virtual services, physical services such as shelters faced changes as a result of the COVID-19 pandemic. In a spatial analysis conducted of 15 women's shelters in Ontario, Canada, it was found shelters experienced up to a 56 percent decrease in shelter space (McLean & Wathen, 2022). This pattern of decreased physical space negatively impacted service availability which has very real implications for mental health services, as shelters often act as a referral point for mental health services (Finn & Stalans, 1995). To overcome physical space limitations many shelters shifted to the use of hotels as temporary housing options for women experiencing violence during the COVID-19

pandemic (Mantler et al., 2021). Mantler and colleagues (2021) reported that although the use of hotels as both quarantine centers for women coming into the shelter and temporary shelters for women with lower risk of violence may have provided physical safety, the quickness with which this solution was implemented resulted in increased burden for staff with staff reporting a decrease in the quality of service provided (Mantler et al., 2021). Though hotels were critical in providing safe physical spaces at a time when shelters had decreased capacity, findings suggested that hotels did not provide women with access to the full range of services, including mental health services, that are typically available when women stay at the shelter (Mantler et al., 2021). Despite shelters enacting workarounds to ensure women had access to services in times of strict public health guidelines, these workarounds often negatively impacted service quality.

2.4.1.3 Racialization and Mental Health Services During COVID-19

Intersectionality suggests people's experiences are shaped by their multiple social positions (Crenshaw, Kimberle, 1989). Intersectionality impacts access and satisfaction with mental health services for women experiencing IPV as power-sharing dynamics may exist between women and their service providers (Kulkarni, 2019). For instance, some racialized communities reported decreased rates of IPV-related calls to police (Baidoo et al., 2021). Decreases were explained by the potential impact of the greater social climate on police reports for Black populations (Baidoo et al., 2021). For instance, Black communities in Chicago experienced a decrease in domestic violence police reports in early 2020, coinciding with political protests in response to police-related deaths of a Black woman, Breonna Taylor, and a Black man, George Floyd (Baidoo et al., 2021). This demonstrates the existence of co-occurring pandemics with changes to mental health services during the COVID-19 pandemic emphasizing the increased experiences of IPV for women during the pandemic, and underscoring that racialized communities face additional barriers in accessing mental health services due to the ongoing racism pandemic. In an American study that examined the impact of the COVID-19 pandemic on the safety, housing stability, and mental health of racialized people who had experienced domestic violence, it was found before the pandemic, participants were accessing services through domestic violence agencies and improvements were seen in

their housing stability, experiences of abuse, and mental health symptoms; whereas, participants' improvements plateaued at the onset of the COVID-19 pandemic (Chiaramonte et al., 2022). This suggests the shift from in-person to virtual service delivery inhibited mental health service access for women experiencing violence, especially for vulnerable and marginalized populations (Chiaramonte et al., 2022). A qualitative descriptive study conducted in Canada revealed inequity in the impact of COVID-19 on IPV service accessibility (Michaelsen et al., 2022). Specifically, marginalized women, including women who were immigrants, refugees, and older adults were disproportionately affected thus experiencing additional challenges in accessing needed IPV services (Michaelsen et al., 2022). Experiences during the COVID-19 pandemic demonstrated the existence of a pandemic hierarchy where policy decision-makers prioritized the COVID-19 pandemic while simultaneously reframing concurrent pandemics such as anti-racism and gender-based violence as movements or shadow pandemics (Mantler et al., 2023). A hierarchical perspective on pandemics failed to recognize the intersectional nature of not just the experiences of each pandemic, but the relatedness of their root causes (Mantler et al., 2023). Together, these studies reveal intersecting challenges for women experiencing IPV during the COVID-19 pandemic and opportunities for further exploration of these women's perspectives.

2.5 Innovation in Service Delivery

2.5.1 Innovations in mental health service delivery during the COVID-19 pandemic

As a result of the COVID-19 pandemic, several innovations were enacted or suggested to support ongoing service delivery. Specifically, delivery channels were shifted so service could be offered while adhering to public health guidelines. Further multi-sectoral collaboration and a gendered lens were suggested as ways to support ongoing service delivery during the COVID-19 pandemic. Each of these will be discussed in turn.

2.5.1.1 Delivery Channels

IPV agencies recognized the need for innovation in service delivery modalities during the COVID-19 pandemic (Jack et al., 2021). Innovation during the COVID-19 pandemic to adhere to public health guidelines was often synonymous with virtual or online-based services. In rural communities' inaccessibility was attributed to limited network connection, as some domestic violence services shifted to delivering counselling sessions via telephone, SMS, and email (Emezue, 2020). However, beyond virtual-based services other agencies found ways to offer in-person services while still adhering to the public health guidelines (Moyer et al., 2022). Parking lot advocacy programs are one such example and were when staff met with women, physically distanced in the parking lot to provide in-person care (Moyer et al., 2022). Another workaround implemented was providing women experiencing IPV with cell phones thereby ensuring they have access to a safe telephone line. This was done to decrease barriers to participation in the virtual services (Moyer et al., 2022). Though service providers in this study deemed this innovation to be effective, little is known about women's satisfaction with this innovation (Moyer et al., 2022). Although the facilitators and innovations presented in this section demonstrate the rapidly changing nature of service delivery during the COVID-19 pandemic, they also meant that staff were implementing novel delivery methods with little training and support (Slakoff et al., 2020). A reality that has resulted in high levels of burnout among service providers with little to no evidence on the satisfaction of these services among service users (Slakoff et al., 2020).

2.5.1.2 Multi-sectoral collaboration

A global commentary on the state of IPV services during the COVID-19 pandemic suggested facilitating the use of mental health services by calling for multi-sectoral collaboration to ensure that women's needs were met (United Nations Women, 2020). The suggested multi-sectoral collaboration is an approach that incorporates a coordinated response amongst relevant stakeholders (United Nations Women, 2020). A study in the United States by Sabri and colleagues (2020) (N=45), suggested the potential of publishing domestic violence information in public spaces for women who may not have had access to a safe computer during the COVID-19 pandemic (Sabri et al., 2020).

Publishing this type of messaging during the pandemic would theoretically enable women to have greater knowledge of which services were available to them during the pandemic. Leveraging public advertising for IPV service awareness is an example of collaboration of all forms between sectors that may be valuable for women experiencing IPV (United Nations Women, 2020). While this potential demonstrates theoretical efficacy, to date no such interventions have been employed (Slakoff et al., 2020).

2.5.1.3 A gendered lens to the COVID-19 pandemic response

A gendered lens is an approach that recognizes the nuances in experiences and how they tie to one's gender (DeFrancisco & Palczewski, 2007). Employing a gendered lens to the COVID-19 pandemic response would ensure equitable investment in the IPV sector and ensure the implementation of key learnings for future pandemics. A qualitative analysis conducted in Canada revealed that executive directors of shelters felt as though the aftereffects of the pandemic on IPV services may be mitigated by employing a gendered lens in the recovery plan (Mantler, Burd, et al., 2022). This would allow for the recognition of the unique challenges faced by women during the COVID-19 pandemic (Mantler, Burd, et al., 2022). Participants expressed hope that a gendered lens would enable future generations to recognize the impactful work of women in the IPV sector in Canada (Mantler, Burd, et al., 2022). Ultimately, though service providers were able to think quickly and adjust service delivery as needed, little is known about the impact of these adjustments from the perspective of the women experiencing IPV themselves. While the COVID-19 pandemic drove innovation in service delivery by shifting to virtual modalities, implementing parking lot advocacy, and promoting multi-sectoral collaboration, for many organizations these changes posed new barriers for women experiencing IPV in accessing services (Garcia et al., 2021). This finding suggests that though service providers implemented innovative methods for service delivery, there remains a gap in ensuring that services satisfy the needs of women experiencing IPV during a crisis (Mantler, Burd, et al., 2022).

Together, changes in delivery channels for domestic violence programs, the use of public advertising, and the implementation of a gendered lens are all examples of innovations and facilitators that may have mitigated the negative effects of the COVID-19 pandemic

on mental health service delivery in the IPV sector. Though most innovations that were implemented were focused on virtual service delivery, it is clear that leveraging various sectors may have allowed for increased accessibility of mental health services for women experiencing violence during this time. More research is needed to understand how various stakeholders may collaborate in future pandemics to ensure steady access and satisfaction with mental health services for women experiencing IPV.

2.6 Barriers to Mental Health Services for Women Experiencing IPV During the COVID-19 Pandemic

During the COVID-19 pandemic, several unique barriers to mental health services emerged. Particularly, the transition from in-person to virtual services results in barriers in terms of accessibility and discomfort with the virtual format of services, staff capacity barriers, and the conflicting tension between the risk of contracting COVID-19 and the need for mental health services. Each of these will be discussed in turn.

2.6.1 Transitioning from in-person to virtual service delivery

Many services were switched to virtual formats as a workaround for physical distancing requirements during the COVID-19 pandemic. Virtual services may include the use of mobile applications for remote monitoring and leveraging video-conferencing technology for one-on-one sessions with women (Emezue, 2020). However, with the shift to virtual modalities, several barriers to mental health services emerged including inaccessible services, impersonal services, and lack of cohesion in service delivery. Barriers to mental health services for women experiencing IPV during the pandemic included that the transition made services inaccessible and virtual services were uncomfortable with virtual services.

2.6.1.1 Inaccessible

Service providers reported that women described virtual services as inaccessible due to increased technology monitoring, lack of privacy, and lack of devices during the COVID-19 pandemic and associated implemented public health guidelines. Many women reported increased technology monitoring during the COVID-19 pandemic by their

abusive partners, and thus although services might have been available, they were not available to women as they were fearful their abusers would know if they attempted to access the mental health service (Emezue, 2020; Kaukinen, 2020). Service providers also reported hearing that women were not comfortable accessing services when their abusive partners were home and given the long duration of stay-at-home orders, this meant that for multiple long periods services became inaccessible for women (Emezue, 2020; Kaukinen, 2020). In rural communities' inaccessibility, was attributed to limited network connection, a well-known limitation of rural broadband infrastructure (Emezue, 2020). Additionally, a community-based research study that included 30 IPV service stakeholders from across Canada, reported the lack of access to technological devices for women as being a key barrier for women experiencing IPV to access services that may have shifted to virtual modalities (Toccalino et al., 2022).

2.6.1.2 Discomfort with virtual services

Moving services to virtual formats left many existing service users feeling uncomfortable which increased their reluctance to share information (Sapire et al., 2022). In an American quality improvement pilot study (N=552) that examined the effectiveness of a remote monitoring technology on pregnant people experiencing IPV, the authors reported that those who are sheltering in place with an abusive partner were reluctant to disclose experiences of IPV in the new virtual format (Krishnamurti et al., 2021). In a Canadian mixed-methods study (N=24) that examined the experiences of IPV service providers during the COVID-19 pandemic, crisis counsellors reported difficulty in gaining the trust of program participants through virtual modalities (S. Montesanti et al., 2022). Further, findings from a qualitative interpretative description study that interviewed shelter staff (n=26), shelter clients (n=8), and a system advocate (n=1) in Ontario revealed that some women did not feel comfortable receiving counselling via phone while they were isolating with their children in shelters as per the COVID-19 pandemic guidelines (Mantler et al., 2021). This was because women felt that they could not be transparent with their counsellors out of fear that their children would overhear their conversations, which were not appropriate for their children to hear (Mantler et al., 2021). This suggests that although virtual modalities may have been helpful for service delivery in terms of

allowing the services to continue to run during the stay-at-home and physical distancing orders; however, this shift to virtual left some women experiencing violence with no access or increased discomfort in using mental health services, despite the existing need. Together these barriers underscore that switching to virtual services from in-person services was intended to improve access to services during stay-at-home orders; however, this switch created new barriers for women experiencing IPV in accessing mental health services.

2.6.2 Staff Capacity & Operational Processes as Barriers to Access to Mental Health Services

Staff capacity and operational processes are key pillars in the delivery of effective mental health services. A posited reason for the reduction in IPV service use was that the transition to online services coupled with stay-at-home guidelines created additional barriers for service providers such as a lack of capacity building for staff and inefficient triage processes (Evans et al., 2020). Capacity building is the "development of knowledge, skills, commitment, partnerships, structures, systems and leadership" to enable effective mental health service delivery (DeCorby-Watson et al., 2018). Capacity building is necessary to ensure that service providers feel equipped to deliver care (DeCorby-Watson et al., 2018). The triage process is an operational process that is taken to assess the priority for access to services in a health context (Hitchcock et al., 2014). Public health guidelines amidst the COVID-19 pandemic impacted the efficiency of triage processes resulting in disruptions in service delivery (Evans et al., 2020). An IPV service organization in the United States reported challenges in capacity building via training of staff to deliver trauma-sensitive care through virtual platforms, therefore impacting the quality of services available for women experiencing IPV during the pandemic (Evans et al., 2020). A main challenge of the pivot from in-person to virtual service delivery also identified by this team was the decreased satisfaction with services because service providers felt that virtual care was less efficient than in-person care, especially when it came to the development of safety plans (Moyer et al., 2022). In addition, in a mixed-methods study that distributed surveys to shelters in Norway (N=56), Bergman and colleagues suggested the impact of the lack of capacity building, a

decline in financial resources, and security which impeded staff's ability to function optimally during the pandemic (2021). Meaning that staff felt they were not adequately trained to deliver mental health services to women experiencing IPV during the pandemic (Bergman et al., 2021).

2.6.2.1 Challenges for service providers

Intimate partner violence service providers have reported experiencing secondary traumatic stress because of the consistent exposure to supporting those who have experienced violence pre-pandemic (Brown-Cotten, 2022). However, before the COVID-19 pandemic, service providers were able to leverage informal peer support with their colleagues as buffers for secondary trauma (Crivatu et al., 2023). During the COVID-19 pandemic, it was found that remote work blurred the boundaries between home and work, as both were occurring inside their home, resulting in the trauma of their work "remaining inside their houses" (Burd et al., 2022). Staff expressed feelings of frustration and loneliness during a time of increased workload (Burd et al., 2022). This increased burden on service delivery personnel may have ultimately limited their ability to deliver satisfying care to women experiencing violence (Burd et al., 2022). This suggests that the implementation of virtual service delivery may have hurt workplace culture and staff cohesion (Burd et al., 2022). Though virtual service delivery may seem like the easiest option to adhere to public health guidelines, the quick shift was a challenge to service providers (Burd et al., 2022).

2.6.3 The tension between the risk of contracting COVID and the need for mental health services

Beyond barriers in transitioning services to virtual formats during the COVID-19 pandemic, another major barrier is the limited availability and complete closure of some

services during the pandemic (MacGregor et al., 2023). In response to the influx of COVID-19 cases, medical and human resources were diverted, and limited attention was explicitly reserved for IPV mental health services (Cullen et al., 2020; Johnson et al., 2020). This shift in healthcare to focus on infectious disease meant women experiencing IPV had reduced opportunities to access healthcare support relevant to their experiences (Johnson et al., 2020). Though there are limited studies that highlight the specific opportunity costs of diverting resources that would have otherwise been used to address the mental health needs of women experiencing IPV during the COVID-19 pandemic, scholars have commented on the impact of staff redeployment. A commentary on mental health services for people experiencing domestic violence in Europe explored the role of psychiatry in addressing the effects of domestic violence during the COVID-19 pandemic (Gulati & Kelly, 2020). It was reported that the redeployment of psychiatric staff to COVID-19-related care may have disrupted the continuity of care for women experiencing IPV, which increased the risk of mental health challenges and experiences of abuse (Gulati & Kelly, 2020).

2.6.3.1 COVID-19-related service disruptions

Women who were at risk of contracting COVID-19 or living with individuals vulnerable to the virus may have decided not to seek acute care out of fear of potentially exposing themselves or family members to the virus (Gulati & Kelly, 2020; Kaukinen, 2020). The shuttering of IPV services in favour of either COVID-19 pandemic services or out of fear of spreading the virus meant there were near continual violent service disruptions during the pandemic (Kearon & Risdon, 2020). The constant interruptions to violence services caused by the dynamic pandemic-related public health guidelines meant women may not have been receiving up-to-date information on the availability of services during the pandemic (United Nations Women, 2020). The lack of up-to-date information limited women's knowledge of mental health services during the COVID-19 pandemic, this may have ultimately led to a decrease in accessibility of key services (United Nations Women, 2020). More quantitative research is needed to examine how women in Canada were impacted by service disruptions during the pandemic beyond the perspectives of service providers.

2.6.3.2 COVID-19 and service use

During the COVID-19 pandemic women reported feeling confined as quarantine guidelines limited movement (Ravi et al., 2021). A woman from this particular qualitative study described this dynamic as being similar to that of her abusive relationship (Ravi et al., 2021). Examples of this control include that women had to have additional medical testing (a negative COVID-19 test) and/or in some cases proof of vaccination to be admitted to the shelter (United Nations Women, 2020).

2.7 Gap in literature

The rise in incidence, prevalence, and severity of IPV coupled with the rapid changes to service delivery and social isolation stemming from the COVID-19 pandemic and associated public health guidelines is concerning. Women experiencing violence were at increased risk at a time when there were increased needs for mental health services. The current literature focuses on the experiences of service providers and the operational challenges of delivering accessible and effective services to women experiencing violence during the COVID-19 pandemic; however, what is missing is the voice of women. As a result, researchers have called for an investigation to understand the help-seeking experiences of women experiencing IPV during the COVID-19 pandemic (Ravi et al., 2021; Slakoff et al., 2020; Su et al., 2021).

3 Chapter 3

Methods

The purpose of this comparison study was to examine the differences, in mental health service accessibility and service satisfaction during the COVID-19 pandemic between women in abusive relationships and women in non-abusive relationships in Ontario.

3.1 Study Design

This cross-sectional study was a sub-study of a larger project: The Impact of a Self-Compassion Intervention on the Resilience and Mental Health of Women who have Experienced Intimate Partner Violence (HEART). The HEART study was a repeated measures, mixed-methods study which aimed to (1) to examine the impact of a 1-month self-compassion intervention on the mental health and resilience of women who are experiencing IPV; (2) to explore the differences, if any, in self-compassion, resilience, and mental health between women out of their relationship compared to women currently in a violent relationship, and; (3) to understand women's lived experiences of self-compassion, resilience, and mental health. This sub-study specifically focused on mental health service delivery during the COVID-19 pandemic among women who had experienced IPV/were experiencing IPV in Ontario. Ethics approval was obtained from the Institutional Research Board of Western University through the web-based platform Western Research Ethics Manager (NMRED 2022-120116-65308; Appendix A).

3.2 Sampling, Eligibility, and Recruitment

3.2.1 Sampling

A purposive sampling technique was used to recruit 44 women from across Ontario. Women in relationships, both violent and non-violent were specifically targeted during recruitment. A sample size of 46, 23 women from abusive relationships and 23 from non-abusive relationships deemed sufficient to achieve 90 percent power to detect a large effect size (i.e., f2 = 0.5) at a significance level of $\alpha = 0.05$ (Erdfelder, E et al., 1996).

3.2.2 Eligibility criteria

Eligibility criteria were consistent with that of the broader HEART study including that the participant must (1) identify as a woman, (2) be in a relationship, (3) live in Ontario, (4) be fluent in English, and (5) have access to a safe computer and telephone. Each of these questions was assessed using yes/no questions in the enrollment survey. Identifying as a woman was included in the inclusion criteria because of the gendered nature of IPV and was assessed broadly as 'do you self-identify as a woman'. Given the rapidly

changing public health guidelines that were unique to various geographical areas, Ontario was selected to allow for a more fulsome comparison while reducing contextual variation. Ontario is Canada's most populated province with a population of over 14 million people with 54.1 percent of individuals between the ages of 25 and 64 (Government of Ontario, 2021). Rural areas in Ontario are home to less than 1,000 people and have a population density of under 400 square kilometres, 17.8% of Ontario's population lives in rural areas (Government of Ontario, 2022). Of women aged 15 or older who had been in at least one intimate relationship, 44% reported having experienced a form of IPV during their relationship with the most common being psychological abuse (Government of Ontario, 2022). In the context of this study, the COVID-19 pandemic was as of March 2020 onward (Tam et al., 2021).

Given the high rates of IPV in this province and the importance of mental health services for women experiencing IPV, it was imperative to explore access and satisfaction with mental health services during a global crisis such as the COVID-19 pandemic.

Participants had to be fluent in English to ensure comprehension because all research study communications were conducted in English. Finally, all participants had to have access to a safe computer and telephone so as not to compromise the safety and well-being of research participants, especially those experiencing violence. Lastly, for half the sample, an additional criterion of being in an abusive relationship was utilized. This was assessed via a yes or no question asking if their current relationship was abusive. Sampling was purposive in that once we had reached 23 participants in the non-abusive cohort then the sampling focused on recruiting women in abusive relationships.

3.2.3 Recruitment

Recruitment was conducted through a two-pronged approach: (1) posting recruitment materials on social media groups; and (2) requesting that community groups refer participants. Leveraging social media platforms included posting 417 advertisements across Ontario, Canada using Kijiji and 30 group posts on Facebook between September 19, 2022, and March 31st, 2023 (see Appendix B). On Facebook, abusive relationship advice groups and buy and sell groups were targeted towards the end of recruitment once

all participants from the non-IPV group were recruited. Furthermore, recruitment materials were shared with community outreach groups, including Cornerstone Family Violence Prevention Centre and the Regional HIV/AIDS Connection. Though community groups were willing to refer clients to the study, no community groups consented to posting recruitment materials directly on their social media channels. Interested participants were directed to complete the online enrollment survey via Qualtrics to confirm eligibility.

Each recruitment poster included a QR code which led participants to the enrollment survey. The online enrollment survey presented the letter of information, consent of participation, and captured demographics and identification information to confirm eligibility. In addition to their email, participants were asked to create and enter their unique participant ID using the last two letters of their last name, the last four numbers of their phone number, and the first two letters of their birth month. Identification was needed to follow up with eligible participants for the baseline survey and deliver gift card honorariums as needed. Participants who were eligible for the study were then emailed the baseline survey link which included the surveys detailed below. Upon completion of the baseline survey, participants were emailed a link to a 5$ Amazon gift card honorarium in recognition of their contribution to this research. In total, 1779 responses were received for the enrollment survey and 66 respondents completed the baseline survey.

3.2.4 Recruitment challenges

The intended sample size for this study was 23 women who had experienced violence and 23 who had not. However, due to challenges including automated survey completions and recruiting women experiencing violence, recruitment halted prematurely for the IPV group.

3.2.4.1 Bots

Recruitment challenges arose when the study received hundreds of enrollment survey completions per day submitted minutes apart at a rapid unrealistic pace. These completions had email addresses formatted identically as

“firstnamelastname@gmail.com”. Upon further investigation, it was discovered that many of these enrollment completions could be tracked to IP addresses outside of Canada (ie. Taiwan and India). To mitigate this, an ethics amendment was submitted to Western’s NMREB for a captcha page to confirm that the survey was being completed by a human. Though the automated completions slowed down after this, they did not stop completely, making it challenging to sort through and identify human respondents compared to research bots.

3.2.4.2 Slow recruitment of women experiencing violence

In addition to the presence of automated bots completing the enrollment survey impacting recruitment, it was difficult to recruit women who had experienced violence for this study. Despite contacting community organizations which serve women experiencing IPV, recruiting this group proved to be a challenging task. Recruitment lasted from September 2022 to March 2023. The main researcher shared recruitment materials directly with community development professionals in their network in an attempt to increase recruitment. Given that the larger HEART study was an intervention study, ensuring participants were recruited at a similar time was important. The last non-IPV participants were recruitment February 2023, whereas by March 2023 we had only recruited 18 participants in the IPV groups. Ultimately did not reach our target sample for the IPV group however, considering the needs and fidelity of the larger intervention study the investigators decided to stop recruitment.

3.3 Data Collection

Data was collected using a survey administered online via Qualtrics. After confirming eligibility through the enrollment survey, participants were sent a link to the baseline survey to complete. The four blocks of the baseline survey were: (1) Demographics; (2) the Mental health service list questionnaire; (3) The client satisfaction questionnaire (CSQ-8); and (4) The barriers of access to care questionnaire (BACQ) (See Appendix C for all blocks)

3.3.1 Safety

To ensure participant safety during data collection an emergency “exit survey” button that leads to google.com was embedded at the bottom of each survey window. In addition, participants were provided instructions on how to complete the survey using a private browsing window. This safety plan has been implemented successfully by Canadian researchers with people experiencing violence for over twenty-five years (Ford-Gilboe et al., 2006).

3.3.2 Demographics

Demographic variables were collected to gain an understanding of the diversity of the research participants including gender, age, highest education level achieved, ethnic origins, sexual orientation, relationship status, type of community they live in, number of children (if any), who they live with, employment status, and information on their average annual income. Ethnic origins and average annual income were asked as open-ended questions with the rest of the variables being asked as multiple-choice questions.

3.3.3 Mental Health Service List Questionnaire

A list of mental health services created in collaboration with the master's student and the principal researcher based on literature detailing which services were being accessed by women who have experienced IPV (Ben-Porat, 2020; Bonomi et al., 2009; Clevenger & Roe-Sepowitz, 2009; Fowler et al., 2011; Sabina & Ho, 2014). This includes mental health services ranging from pharmacotherapy and psychotherapy delivered in acute care settings to community-based mental health support provided by shelters and community groups (Moroz et al., 2020). Police are included in this because they may be in the position to provide emergency mental health services to women experiencing IPV through crisis intervention teams (Wood et al., 2017). This list included primary health care providers, urgent care clinics, emergency rooms, shelter services, pharmacies, police, mental health centers, crisis lines, religious services, psychiatrists, women’s community centers, counsellors, support groups, and others. The ‘other’ option was inputted to enable women to describe any services that they accessed that were not included in the list. For each service, participants were asked “which one of (if any) of

the below services have you accessed in the past 12 months?". The response options were: (1) Yes (what were the barriers, if any?) (2) No (3) Needed but could not access. (Why?). All open-ended answers were optional. The goal of this section was to gain an understanding of the diversity in the types of services being accessed by participants and barriers to accessing services. The purpose of this section was to address a key gap in research, specifically asking about specific service needs with mental health services as well as barriers to each service (Ford-Gilboe et al., 2015). This questionnaire was created as no validated tool was available to capture this data.

3.3.4 Mental Health Service Satisfaction as Measured by The Client Satisfaction Questionnaire (CSQ-8)

Mental health service satisfaction was measured using the Client Satisfaction Questionnaire-8 (CSQ-8). The CSQ is an 8-item scale that measures patient satisfaction with mental health services. The CSQ-8 uses a 4-point Likert scale ranging from 1(poor) to 4 (excellent). Higher scores denote a more satisfactory patient experience whereas lower scores indicate lower satisfaction with mental health services (Attkisson, C & Greenfield, Thomas, 2004). This scale has been validated in mental health outpatient settings and has a Cronbach's alpha of .83 to .93 indicating very good internal reliability (Potter et al., 2017)s3 . This scale has demonstrated construct validity and high levels of internal consistency (Attkisson, C & Greenfield, Thomas, 2004). Examples of questions asked by the CSQ-8 are "How would you rate the quality of service you have received?" and "In an overall general sense, how satisfied are you with the service you have received?".

3.3.5 Access to Mental Health Services as Measured by The Barriers of Access to Care Questionnaire (BACQ)

Access to mental health services was measured using the Barriers of Access to Care Questionnaire (BACQv3). The BACQv3 is a comprehensive measure developed in the United Kingdom for individuals over the age of 18 who are at various stages of the help-seeking process to assess barriers to seeking mental health treatment (Clement et al., 2012; Hongo et al., 2021). The BACQv3 is a 30-item tool using a 4-point Likert scale ranging from (0) not at all to (3) a lot. Examples of statements included in the BACQv3

are “Being unsure where to go to get professional care” and “Preferring to get alternative forms of care (e.g. traditional/religious healing or alternative/complementary therapies)”. While the tool does not have any subscales, overall lower scores indicate a lower barrier to seeking treatment whereas higher scores indicate higher barriers to seeking mental health services (Clement et al., 2012). The scale was found to be reliable with a good internal consistency with Cronbach’s alpha ranging from 0.7-0.89 (Clement et al., 2012).

3.4 Data Analysis

3.4.1 Sample Composition

All demographics were analyzed using measures of central tendency and dispersion.

3.4.2 Data cleaning & missing data

Both the CSQ8 and the BACQv3 do not have a predetermined protocol for missing scores beyond the method described above. A data cleaning protocol was developed to refine the data, address missing values, and check for outliers, and duplicates. For both the CSQ-8 and the BACQv3, unretrievable missing values will be removed, and the overall score will be calculated with the available data. Should there be missing data within the scales, pairwise deletion will be implemented, meaning a participant’s data will be eliminated only when the data point needed to test a particular assumption is missing (Kang, 2013).

3.4.3 Scale preparation and scoring

CSQ-8 scores were tabulated according to the scoring protocol by Attkisson and Greenfield (2004). An average sum was calculated by summing the sum of each participant's item rating score with a higher score indicating higher satisfaction (Attkisson, C & Greenfield, Thomas, 2004). The CSQ-8 does not have a predetermined threshold but has a minimum score of 8, and a maximum score of 32 (Attkisson, C & Greenfield, Thomas, 2004). A similar process was taken for the BACQv3 scores where higher scores indicate greater barriers to seeking mental health services (Clement et al., 2012). The minimum score for the BACQv3 is 0 whereas the maximum is 90. Responses to the optional open-ended question in the BACQv3 will be noted and used to provide

additional context to results from the main analysis of variance. There were four optional open-ended questions prompting participants to elaborate on the barriers, if any. No participants provided answers to these questions.

3.4.4 Analysis

To answer the research question, descriptive statistics were computed each for mental health service satisfaction and mental health service access as measured by the CSQ-8 and BACQ, respectively.

3.4.5 Mental health service satisfaction

The two groups being compared were women who are in a relationship and have experienced IPV and women who are in a relationship but have not experienced IPV in their current relationship.

To examine the impact of experiences of IPV on mental health service satisfaction, the mean CSQ-8 scores for both women who had experienced IPV in the past 12 months and women who had not experienced IPV, were computed and compared.

To examine the open-ended question, a thematic analysis was conducted to capture women's experiences with specific mental health services. This methodology was chosen as it is best for uncovering patterns from the perspective of people who are experiencing barriers (Braun & Clarke, 2006). Open-ended responses that were provided for each mental health services were organized and summarized; common themes were noted for each service before results were summarized across all mental health services which had open-ended responses. Inductive coding was chosen as the methodology of analysis given the exploratory nature of the research question (Thomas, 2003).

3.4.6 Barriers of Access to Mental Health Services

To examine the impact of experiences of IPV on barriers to access to mental health services, the mean BACQv3 scores for women who had experienced IPV in the past 12 months and women who had not experienced IPV, were computed and compared.

3.5 Self-Reflection

As a young Black woman in academia, I have struggled in accessing mental health services that give me high levels of satisfaction and have limited barriers to access. I recognize my privilege in having access to mental health services through various avenues. My personal experiences coupled with my academic interest in service utilization have led me to value the importance of effective mental health service delivery, especially for populations who are experiencing intimate partner violence during the pandemic. As such, in my professional scope, I want to amplify the experiences of women experiencing IPV in hopes of improving mental health service delivery as we continue to navigate a world where both COVID-19 and IPV exist. I recognize that my passion for improved service delivery and my individual experiences with sub-par mental health services may be a potential confirmation bias. To mitigate this, I have detailed objective quantitative analysis methodologies and will ensure that I am hyperaware of how my potential biases so that my assumptions do not taint the data.

4 Chapter 4

Results

This chapter provides an overview of the results of this study which investigates how mental health service access and satisfaction for women experiencing IPV were affected by the COVID-19 pandemic. Most importantly, these results capture the perspectives of women themselves.

4.1 Sample Description

In total, the baseline survey was completed by 44 women, after cleaning and removing duplicates, 39 sets of participant data were included in analysis. Of this, 16 reported experiencing IPV in their current relationship and 23 reported not experiencing IPV. Of the 39 participants, 20 participants indicated that they had used mental health services, 13 who had not experienced IPV and 7 who had experienced violence. The demographics table details the demographics of all participants included in the analyses (see Appendix E).

4.1.1 IPV Group

There was diversity in sexual orientations, with the representation of lesbian women (6.25%, n=1), heterosexual women (62.5%, n=10), bisexual women (25%, n=4), and pansexual (6.25%, n=1). The median age was 34 years (s=9.8) with all the women living in an urban community (100%, n=16). Most women (81.3%, n=13) indicated that they had some sort of post-secondary education. Ethnically, many women identified as having multiple ethnicities (31.3%, n=5), Asian (18.8%, n=3), White (31.3%, n=5), with only one woman being Indigenous to Canada (6.25%, n=1). Moreover, most women reported that they did not have children (56.3%, n=9). The median income of this population was 50 000$ (s=$27687.7) with most women reported being employed full-time (75%, n=12), casual workers (18.8%, n=3), and one sex worker (6.25%, n=1).

4.1.2 Non-IPV Group

Most women identified as heterosexual 17 (69.6) or bisexual 7(30.4). The median age of this group was 26.5 (s=11.19) with women living in both urban 19 (82.6) and rural communities 3 (13), respectively. Further, some participants were unsure of what type of community they lived in 2 (8.7). Most women had some post-secondary education 21 (91.3). Ethnically, many women identified as having multiple ethnicities 6 (26), Asian 6 (26), White 3 (13), while one woman identified as First Nations 1 (4.3). Moreover, most women reported that they did not have children 20 (86.9). The median income of this population was 50 000$ (sd=37695) and most women reported being employed full-time 24 (47.8).

4.2 Results for Mental Health Service List Questionnaire

In total, of the 13 women in the non-IPV group who reported access to mental health services, the highest reported service was pharmacies with 46 percent (n=6) self-reported usage. Following this, 38 percent (n=5) of women in the non-IPV group accessed primary healthcare providers. The third most used mental health services amongst the on-IPV group in this sample were psychiatrists at 31 percent (n=4). In the non-IPV group, the average and standard deviation in those who accessed services were 2.0 and 2.1, respectively (See *Table 1*).

Similarly, primary health care providers were also one of the top accessed services for women in the IPV group with 71 percent (n=5) reporting accessing both psychiatrists and primary health care providers. The third most reported mental health services were pharmacies, police, counsellors, support groups, and 'other' at 43 percent (n=3). In the IPV group, the average and standard deviation in those who accessed services was 2.6 and 1.4, respectively (See *Table 2*)

Table 1: Mental Health Service List Questionnaire Responses (Non-IPV Group)

Services	1 – Yes,	2 – No, did	3- Needed but did not
Primary Health Care Providers	5 (38.5)	8 (61.5)	0
Emergency Room	0	12 (92.3)	1 (7.7)
Shelter Services	0	13 (100)	0
Pharmacy	6 (46.2)	7 (53.8)	0
Police	3 (23.1)	4 (30.8)	0
Mental Health Center	0	13 (100)	0
Crisis Lines	1 (7.7)	11 (84.6)	1 (7.7)
Religious services (priests, minister,	0	13 (100)	0
Psychiatrist	4 (30.8)	9 (69.2)	0
Women Community Centers	0	13 (100)	0
Counselor	3 (23.1)	10 (76.9)	0
Support Groups	3 (23.1)	10 (76.9)	0
Other[1]	2 (15.4)	11 (84.6)	0
		Sd=2.1	

1 Though women were given the option to describe which 'other' services they may have accessed and despite this being chosen as an option, no responses were

Table 2: Mental Health Service List Questionnaire Responses (IPV Group)

Services	No	1 – Yes,	2 – No,	3- Needed
Primary Health Care Providers/	0	5 (71.4)	2 (28.6)	0
Emergency Room	0	0	7 (100)	0
Shelter Services	0	2 (28.6)	5 (71.4)	0
Pharmacy	0	3 (42.9)	4 (57.1)	0
Police	0	3 (42.9)	4 (57.1)	0
Mental Health Center	1 (14.2)	1 (14.2)	5 (71.4)	0
Crisis Lines	0	1 (14.2)	5 (71.4)	1 (14.2)

Religious services (priests, minister,	0	2 (28.6)	5 (71.4)	0
Psychiatrist	0	5 (71.4)	2 (28.6)	0
Women Community Centers	0	1 (14.2)	6 (85.7)	0
Counselor	0	3 (42.9)	4 (57.1)	0
Support Groups	0	3 (42.9)	4 (57.1)	0
Other[1]	1 (14.2)	3 (42.9)	3 (42.9)	0

1 Though women were given the option to describe which 'other' services they may have accessed and despite this being chosen as an option, no

Across both the IPV and non-IPV groups, 20 barriers were identified, of these, 65 percent (n=13) of the barriers were around wait times and lack of knowledge of availability across primary health care providers, crisis lines, and psychiatrists. Other individual responses included costs, cultural barriers, trust in service provider and virtual service delivery. A full list of responses can be found in Appendix F. Though no other responses were recognized as patterns, a response that may be included for its richness is the lack of follow up experienced by a woman from a women's mental health support group.

4.3 Results for satisfaction on mental health services

Total CSQ-8 scores for women experiencing IPV had a mean of 23.71 (sd=6.87, range 8-32), while scores of those who had not experienced IPV had a mean of 20.43 (s=6.20, range 15-32).

4.4 Results for access to mental health services

Total BACQ scores for women experiencing IPV had a mean of 23.11 (sd=8.38, range 8.52-34). while scores of those who has not experienced IPV had a mean of 31.45 (sd=15.37, range 9.62 -56).

5 Chapter 5

Discussion

The purpose of this cross-sectional comparison study was to examine the differences, in mental health service accessibility and satisfaction during the COVID-19 pandemic between women in abusive relationships and women in non-abusive relationships in Ontario. Findings revealed during the COVID-19 pandemic, women experiencing violence had higher levels of satisfaction and lower levels of barriers to access. Interestingly, women in violent relationships reported having similar barriers in accessing mental health services compared to women not in violence relationships. A similar trend was observed in service satisfaction where both groups accessed primary health care providers while they differed in the IPV group accessing psychiatrists and the non-IPV group accessing pharmacies. Furthermore, the main barrier described by women for specific mental health services was systemic shortcomings including long wait times. and lack of availability.

5.1 Trends in accessing mental health services

The trend observed was that the non-IPV group experienced higher barriers of access to mental health services compared to the IPV group. Barriers to accessing services are well documented among women experiencing IPV (Ford-Gilboe et al., 2015) and the general population with barriers typically including long wait times, availability of mental health professionals, stigma, and cost of services (Moroz et al., 2020). The increased barriers in the non-IPV compared to the IPV could be due to the impact of the COVID-19 pandemic on people's mental health. It is well established that the COVID-19 pandemic brought on significant declines in mental health, so much so that a nationwide study conducted between March and May of 2020 reported a decline in mental health among Canadians (Zajacova et al., 2020).

In response to the decline in mental health during the pandemic, service providers implemented digital interventions to both meet the demands and adhere to public health

guidelines (Strudwick et al., 2021). Despite these efforts to maintain access to mental health services during the public health restrictions associated with the COVID-19 pandemic barriers remained which is posited by some researchers to be due to the increased demands in service overloading the health care system (Natasha R. Saunders et al., 2021). This is further supported by a cross-sectional study that examined the unmet mental health service needs of young adults across multiple countries, it was uncovered that the Canadian sample demonstrated a higher unmet need compared to the French sample at 65 percent and 35 percent, respectively (Coulaud et al., 2023). Though findings from this study highlight Canadians' positive attitudes about mental health help-seeking behaviours, they also underscore the increased demand for mental health services during the COVID-19 pandemic (Coulaud et al., 2023). Furthermore, the finding among the general population provides additional context to why women who did not experience IPV reported experiencing new barriers when needing access to mental health services.

Experiences of IPV increased and intensified during the COVID-19 pandemic, especially during periods of physical distancing where women experiencing violence were often isolated from their abusive partners (Lyons & Brewer, 2021). Abusers have been known to maintain control by monitoring technology usage and implementing digital trackers, this type of monitoring can be identified as a form of digital coercive control (Emezue, 2020; Harris & Woodlock, 2019). Women in this study who had experienced IPV had lower barriers to accessing mental health services compared to those not experiencing IPV with one possible explanation being that the increased isolation coupled with the delivery of virtual mental health services meant that women may not have had access to a safe telephone or computer to access these services. Women experiencing IPV in our study may not have experienced barriers to mental health services simply because they knew, based on their previous experiences of violence and history with their abuser that they could not access them. Additionally, women experiencing violence in our study had a higher average number of services used (2.7) compared to those who had not experienced violence (2.0). This difference may be attributed to women experiencing IPV having already been connected to mental health services before the COVID-19 pandemic compared to the non-IPV group. Evidence has established that women in violent relationships are the best positioned to know how to keep themselves safe (Parker &

Gielen, 2014). Though there was an optional open-ended response to describe any additional barriers experienced, women experiencing IPV may not have identified increased surveillance as a barrier because digital coercive control has been normalized, making it difficult for those experiencing this phenomenon to identify it as such (Harris & Woodlock, 2019).

Overall, both the IPV group and non-IPV group reported low satisfaction with services with the IPV group having reported being slightly more satisfied than those in the non-IPV group. This is in line with previous research suggesting that women experiencing IPV during the pandemic were often sheltered-in-place with their abusive partners making it difficult for them to fully engage in services (Emezue, 2020).Specifically, in a Canadian study it was reported that while women had access to counsellors and other shelter-based services when they were sheltering in place with them, they did not have the privacy required to fully engage in the service (Burd et al., 2022).

Additionally, the impersonal nature of some digital services may also have contributed to the lack of satisfaction. Many mental health services implemented during the COVID-19 pandemic were not tailored to the unique needs of women experiencing IPV. A cross-sectional study of 95 Canadian women uncovered that to support women experiencing IPV, empathetic in-person services must be prioritized (Mantler, et al., 2022). This is contrary to the rapid increase in digitally delivered mental health services in Canada (Emezue, 2020). Women in our study may have reported lower rates of satisfaction because the mental health services being delivered during the COVID-19 pandemic were tailored to the needs of the greater population rather than the nuanced experiences of women experiencing (Slakoff et al., 2020). Additionally, women in our study may have had lower rates of satisfaction because of the unique need for trauma-informed and focused mental health services of this population (Sullivan, 2018).

5.2 Service use

For both the non-IPV and the IPV groups, primary health care providers, pharmacies, and psychiatrists were among the top-used mental health services. This is further

contextualized by the main barrier across both groups and various services being long wait times and the lack of availability. Higher service use with pharmacies is not surprising as during the COVID-19 pandemic, pharmacists remained some of the most accessible health service providers as they remained open during stay-at-home orders as they were deemed an essential service (Goff et al., 2020). While both psychiatry and primary health care are also essential services the lack of accessibility could be because many health-care resources were redeployed during the pandemic and highly focused on the COVID-19 virus and associated outbreak (Gulati & Kelly, 2020). Given the shift in focus of primary health care services and frontline health care workers during the pandemic to be COVID-19 focused it is not surprising that women relied on pharmacists for mental health services as their availability remained virtually unchanged throughout the pandemic (Goff et al., 2020). Despite experiencing the worst of the COVID-19 pandemic on the frontlines, pharmacists demonstrated their resiliency by managing to maintain uninterrupted services and continuity of care that was unchanged from the pre-pandemic times (Austin & Gregory, 2021). The unchanged service delivery of pharmacists coupled with the redeployment of other medical health professionals may have left the public confused about which services were available during the COVID-19 pandemic (Gulati & Kelly, 2020). It is well-established that pharmacies remained open despite stringent public health guidelines and sometimes went as far as setting up new pharmacies in temporary COVID-19-specific centers (Goff et al., 2020). This suggests that women in this study may have been more likely to access pharmacies because of their proven availability, continuity of care, and their lack of redeployment to the delivery of COVID-19 care.

As a result of public health guidelines and to curb the spread of the COVID-19 pandemic, many psychiatrists shifted from in-person to virtual service delivery to ensure continuity of care (Öngür et al., 2020). Unsurprisingly, women in our study were more likely to access psychiatric, counselling services and primary health providers because of the use of virtual modalities to deliver services. A population-based study of primary health-care provider service delivery during COVID-19 explored the shift from in-person to virtual service delivery in Ontario between January 1st and July 28, 2020 (Glazier et al., 2021) . Through this study, the researchers uncovered how despite office visits declining by 79.1

percent, virtual service delivery experienced a 56-fold increase during that time (Glazier et al., 2021). However, the increase in accessibility of service providers who were not redeployed to provide human resources for the COVID-19 pandemic and the increase in service use overall may have inhibited individual accessibility to the services. Particularly, women who had been considering seeking psychiatry care may have been more likely to seek out care as they had additional time, because of the stay-at-home orders, and increased accessibility because they could access the care from home (Coulaud et al., 2023). This is specifically true for women in non-abusive relationships, which was the trend observed in this study.

All women in our study were more likely to access psychiatric and counselling services than other formal mental health services, highlighting the role of these services in mitigating mental health challenges. This is in line with existing literature that establishes how women who have experienced IPV are at a greater risk of being diagnosed with depression and post-traumatic stress disorder, thus demonstrating the immediate and long-term need for psychiatric care, especially during times of crisis (Sediri et al., 2020). This is unique because it demonstrates how women can be experiencing IPV while also simultaneously demonstrating help-seeking behaviours amidst a global crisis. This is contrary to literature which suggests declines in help-seeking behaviours. With increases in economic pressures during the COVID-19 pandemic, a systematic review exploring mental health help-seeking behaviours in various populations, women experiencing IPV included, found delays and decreases in help-seeking behaviour (Yonemoto & Kawashima, 2022). Our findings demonstrate that despite the pressures of the COVID-19 pandemic and the barriers to services access, women experiencing IPV may have still been willing to access mental health services.

5.3 Limitations and directions for future research

Findings from this study should be considered within the context of the limitations. Specifically, the sample was not representative of the greater Ontario population as most participants were from urban areas, this suggests that results may not be generalizable to all women accessing mental health services during the COVID-19 pandemic in Ontario. Despite recruitment efforts, this study did not have a broad geographical representation with most women reporting themselves as residing in urban environments. This suggests that results from this study are likely not applicable to rural contexts. The differentiation between urban and rural mental health service delivery is essential considering that each context has unique challenges and nuances impacted by its geographical environment (Letourneau et al., 2023).

There were challenges with recruitment. Beyond the difficulty in recruiting participants of those participants, we did recruit 24 women who were not included in the main analyses because they indicated that they did not access formal mental health services during the COVID-19 pandemic. However, not using formal mental health services does not mean that these women did not use or need to use mental health services during the pandemic, nor does it signify the absence of barriers to accessibility. Further, it is possible that these women accessed informal support during the COVID-19 pandemic. Informal support has been reported as an essential support system for women experiencing IPV, so much so that often prefer their family and friends over accessing formal supports (Ansara & Hindin, 2011). Further, it is possible that women in this study did need to use services but were not accessing them during the pandemic and as such their experiences were not captured in our analysis as we asked if they were using services and if the answer was ‘no’ then they were not asked about if they needed to or if they experienced barriers in service use.

The methodological limitations of this study included the use of an unvalidated mental health list questionnaire, recruitment challenges, the use of self-reported data, and self-response bias. The mental health services questionnaire used to assess which services

were being used by women was created by the principal researcher with support from the research supervisor. Though this questionnaire was constructed in line with existing literature, it is not a validated scale. A further challenge was recruiting women experiencing IPV, this is a common trend in research with women experiencing violence because it is often unlikely that this population has access to a safe computer or telephone to participate in the study, this challenge led to unequal groups and may have led to non-response bias in the study results (McFarlane, 2007). Also, all the surveys in this study were self-reported, meaning that some answers may not be accurate, thus impacting the validity of the results. Furthermore, self-selection bias may have resulted in the recruitment of people with similar characteristics as participants chose to participate in the study on their own.

The literature demonstrates the impact of a women's intersectional identity on how they experience mental health services when experiencing violence (Baidoo et al., 2021). Using an intersectional lens is key to developing solutions that consider multiple perspectives (Crenshaw, 1989). However, due to the small sample size of the dataset this study was unable to explore the intricacies and nuances between sub-populations. Further, though the qualitative data in this study gave women the opportunity to share their unique experiences, due to the small size and the amount of responses received for this optional component, this analysis was limited.

To ensure the development of effective policy and impactful evidence, future research should implement innovative ways for participant recruitment, data collection methods that ensure safety for women experiencing IPV and explore the impact of cultural context on mental health services and IPV during global crises while meaningfully incorporating qualitative methodology.

6 Chapter 6

Conclusion

This study found similar low scores of satisfaction and barriers between the IPV and the non-IPV group. Women experiencing IPV were found to have higher scores of satisfaction and had lower barriers than those who were not experiencing IPV. That said, the study highlights important trends in mental health service accessibility and overall service use by underscoring the importance of communicating the availability of services amidst ever-changing public health guidelines. Future research should examine access and satisfaction of specific mental health services for women experiencing IPV during times of global crisis in Ontario. Women differ in the types of mental health services that they access and so it is critical to identify the barriers that exist in each type of mental health service to understand how best this population can be supported in these services for future global crises.

Policymakers should pay close attention to how they can meaningfully collaborate with private sector actors such as media houses, and traditional media to increase the accessibility of mental health services. For instance, literature has established the potential positive impacts of the use of various types of media in ensuring that women know which services are available to them during times of global crisis (Emezue, 2020; United Nations Women, 2020). Policymakers should also consider collaborating with frontline health workers to ensure that despite the redeployment of health workers to tackle the COVID-19 pandemic, adequate staffing remains for non-COVID-19 – related care.

Frontline health workers may consider the contextual factors that may hinder women experiencing violence from accessing mental health services at home. The prioritization of virtual service delivery may have simultaneously improved and hindered accessibility and satisfaction of mental health services for women. Ultimately, mental health service delivery must remain at the forefront of policy agendas to ensure positive health outcomes for all people living in Canada. Overall, this study identified the unique barriers faced by women experiencing IPV in accessing virtual mental health services and the importance of knowledge of the availability of services during the COVID-19 pandemic for all women. These findings address the lack of literature that captures the experiences in mental health access and satisfaction specifically from the perspective of women experiencing violence during the COVID-19 pandemic in Canada. This is important because the meaningful inclusion of such perspectives is vital in shaping future crisis response strategies in Canada and beyond.

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Appendix A NMREB Ethics Approval Certificate

Western Research

Date: 29 May 2023

To: Dr. Tara Mantler

Project ID: 120116

Study Title: The Impact of a Self-Compassion Intervention on the Resilience and Mental HEAlth of Women in RelaTionships: The HEART Study

Application Type: NMREB Amendment Form

Review Type: Delegated

Full Board Reporting Date: 07/Jul/2023

Date Approval Issued: 29/May/2023 11:06

REB Approval Expiry Date: 17/May/2024

Dear Dr. Tara Mantler,

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the amendment, as of the date noted above.

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Mantler NMREB 120116 Participant Communication May19_23.docx	Information Update Letter	19/May/2023	

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Ms. Katelyn Harris, Research Ethics Officer on behalf of Dr. Riley Hinson, NMREB Vice-Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix B: Location of Kijiji Posts

Location (postal code)	Category	Sub-Category	Date Posted
Example City (N6H)	Buy & Sell	Free Stuff	11-Feb
N6M	Services	Nanny & Childcare	19-Sep
N6L	Services	Health & Beauty	19-Sep
M87	Real Estate	For Rent	19-Sep
L9C	Comunity	Friendship & Networking	19-Sep
L9C	Pets	Found	19-Sep
P2A	Jobs	Childcare	19-Sep
P2A	Buy & Sell	Health & Special Needs	19-Sep
M6L	Buy & Sell	Toys & Games	19-Sep
M69	Jobs	Office Manager & Receptionist	19-Sep
M6J	Real Estate	Rentals	19-Sep
M6C	Jobs	Part time & Students	19-Sep
M6C	Real Estate	For Rent	19-Sep
M6J	Community	Rideshare	19-Sep
M6J	Real Estate	Short term rentals	21-Sep

L96	Jobs	Accounting & Management	21-Sep
M6J	Pets	Birds for rehoming	21-Sep
M6J	Community	Friendship & Networking	21-Sep
M6J	Community	Missed Connections	21-Sep
L9V	Community	Activities & Groups	22-Sep
L9V	Community	Events	22-Sep
L9V	Community	Other	22-Sep
L9V	Community	Rideshare	22-Sep
L9V	Vehicles	Vehicle Parts & Accessories	22-Sep
L9V	Vehicles	Other	22-Sep
L9V	Real Estate	Longterm Rentals	22-Sep
M2N	Vacation Rentals	N/A	22-Sep
M2N	Buy and Sell	Kids and Youth	22-Sep
K9V	Buy and Sell	Kids and Youth	22-Sep
K9V	Buy and Sell	N/A	22-Sep
K9V	Buy and Sell	Books	22-Sep
K9V	Buy and Sell	Furniture	22-Sep
K9V	Buy and Sell	Hobbies and Crafts	22-Sep

K9V	Buy and Sell	Home-Indoor	22-Sep
K9V	Buy and Sell	Toys & Games	22-Sep
K9V	Buy and Sell	Books	22-Sep
L4A	Community	Events	23-Sep
N4K	Community	Events	23-Sep
K6V	Community	Events	23-Sep
L6A	Community	Events	23-Sep
K0A	Community	Events	23-Sep
L4A	Community	Activities & Groups	23-Sep
N4K	Community	Activities & Groups	23-Sep
K6V	Community	Activities & Groups	23-Sep
L6A	Community	Activities & Groups	23-Sep
K0A	Community	Activities & Groups	23-Sep
K9V	Pets	Rehoming	26-Sep
K9V	Pets	Rehoming	26-Sep
K9V	Pets	Rehoming	26-Sep
K9V	Pets	Equestrian & Livestock	26-Sep
K9V	Buy & Sell	CDs, DVD, & Blu Ray	28-Sep

K9V	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
L3T	Buy & Sell	Clothing	28-Sep
K0L	Buy & Sell	Clothing	28-Sep
K0L	Buy & Sell	Free Stuff	28-Sep
L9C	Buy & Sell	Free Stuff	28-Sep
L9C	Buy & Sell	Free Stuff	28-Sep
L9C	Buy & Sell	CLothing	11-Nov
L9C	Buy & Sell	Free Stuff	11-Nov
L9C	Buy & Sell	Clothing	11-Nov

L9C	Buy & Sell	Free Stuff	11-Nov
K9V	Community	Friendship and Networking	11-Nov
K9V	Community	Friendship and Networking	11-Nov
K9V	Community	Friendship and Networking	11-Nov
K9V	Community	Friendship and Networking	11-Nov
K9V	Community	Friendship and Networking	11-Nov
L7A	Buy & Sell	Free Stuff	11-Nov
L7A	Buy & Sell	Free Stuff	11-Nov
L7A	Buy & Sell	Clothing	11-Nov
L7A	Buy & Sell	Clothing	11-Nov
L7A	Buy & Sell	Clothing	11-Nov
L4W	Buy & Sell	Clothing	11-Nov
L4W	Buy & Sell	Clothing	14-Nov
L4W	Buy & Sell	Clothing	14-Nov
L4W	Buy & Sell	Clothing	14-Nov
L4W	Community	Rideshare	14-Nov
N6H	Services	Childcare	14-Nov
N6H	Real Estate	For Rent	15-Nov

N7L	Real Estate	For Rent	15-Nov
N6H	Jobs	Housekeeping	15-Nov
M6C	Buy & Sell	Free Stuff	24-Oct
M6C	Buy & Sell	Free Stuff	24-Oct
M6C	Buy & Sell	Free Stuff	24-Oct
M6C	Services	Cleaners & clEANING	24-Oct
	Community	Volunteers	26-Oct
	Community	Volunteers	26-Oct
	Community	Volunteers	26-Oct
	Real Estate	For Rent	26-Oct
	Jobs	Bar	26-Oct
N6G	Jobs	Healthcare	7-Nov
N6H	Community	Volunteers	7-Nov
N6H	Jobs	Healthcare	7-Nov
N6G	Community	Healthcare	7-Nov
N6G	Jobs	Volunteers	7-Nov
N7X	Services	Tutors & Languages	22-Nov
L6Y	Community	Volunteers	22-Nov

L5A	Services	Other	22-Nov
L2G	Services	Health and Beauty	22-Nov
K0A	Services	Childcare & Nanny	22-Nov
K0G	Community	Volunteers	22-Nov
K0E	Community	Volunteers	22-Nov
K0C	Community	Volunteers	22-Nov
K0B	Community	Volunteers	22-Nov
M6J	Services	Health and Beauty	22-Nov
L6H	Community	Friendship and Networking	22-Nov
N6H	Services	Wedding	23-Nov
M3J	Community	Volunteers	23-Nov
P2A	Buy & Sell	Books	23-Nov
P4N	Jobs	Hair Stylist and Salon	23-Nov
K0A	Community	Long Lost Relationships	23-Nov
L4H	Community	Activities and Groups	23-Nov
M6J	Services	Cleaners & clEANING	24-Nov
L6H	Community	Volunteers	24-Nov
N6H	Community	Volunteers	24-Nov

M3J	Community	Volunteers	24-Nov
P2A	Community	Events	24-Nov
P4N	Jobs	Bar	24-Nov
L6A	Community	Friendship and Networking	25-Nov
K0A	Community	Friendship and Networking	25-Nov
L4A	Buy & Sell	Free Stuff	25-Nov
N4K	Buy & Sell	Free Stuff	25-Nov
K6V	Buy & Sell	Clothing	28-Nov
L6A	Buy & Sell	Clothing	28-Nov
K0A	Buy & Sell	Clothing	28-Nov
K9V	Buy & Sell	Clothing	28-Nov
K9V	Buy & Sell	Clothing	28-Nov
K9V	Buy & Sell	Clothing	28-Nov
K9V	Buy & Sell	Clothing	28-Nov
L4H	Buy & Sell	Free Stuff	26-Nov
L4H	Community	Missed Connections	26-Nov
L6Y	Pets	Accessories	26-Nov
N6K	Real Estate	Selling	26-Nov

K1G	Services	Health and Beauty	26-Nov
M1P	Services	Wedding	26-Nov
M1X	Buy & Sell	Jewelry & Watches	27-Nov
P7B	Pets	Other	27-Nov
P3E	Buy & Sell	Free Stuff	27-Nov
P3E	Community	Volunteers	27-Nov
L1C	Community	Friendship and Networking	27-Nov
L1N	Community	Missed Connections	27-Nov
K0K	Services	Health and Beauty	28-Nov
L6H	Buy & Sell	Arts & Collectibles	28-Nov
P1H	Community	Volunteers	28-Nov
M6J	Services	Entertainment	28-Nov
N1K	Buy & Sell	Clothing	28-Nov
L6Y	Community	Activities & Groups	28-Nov
L9V	Community	Other	29-Nov
L9V	Community	Rideshare	29-Nov
L9V	Vehicles	Vehicle Parts & Accessories	29-Nov
L9V	Vehicles	Other	29-Nov

L9V	Real Estate	Longterm Rentals	29-Nov
M2N	Vacation Rentals	N/A	30-Nov
M2N	Buy and Sell	Toys and Games	30-Nov
K9V	Buy and Sell	Toys and Games	30-Nov
K9V	Community	Friendship and Networking	30-Nov
K9V	Buy and Sell	Books	30-Nov
K9V	Buy and Sell	Furniture	1-Dec
K9V	Buy and Sell	Hobbies and Crafts	1-Dec
K9V	Buy and Sell	Home-Indoor	1-Dec
L6Y	Community	Friendship and Networking	29-Nov
M1X	Services	Health and Beauty	29-Nov
K0K	Community	Long lost relationships	29-Nov
P6A	Services	Health and Beauty	29-Nov
L9C	Buy & Sell	Free Stuff	29-Nov
M1R	Community	Volunteers	29-Nov
P0V	Community	Lost & Found	30-Nov
N6K	Services	Health and Beauty	30-Nov
L1V	Buy & Sell	Free Stuff	30-Nov

N3L	Buy & Sell	Clothing	30-Nov
N2L	Services	Other	30-Nov
N2J	Community	Other	30-Nov
N4K	Services	Nanny & Childcare	1-Dec
K6V	Services	Health & Beauty	1-Dec
L6A	Real Estate	For Rent	2-Dec
K0A	Community	Friendship & Networking	2-Dec
K9V	Pets	Found	2-Dec
K9V	Jobs	Childcare	2-Dec
K9V	Buy & Sell	Health & Special Needs	2-Dec
K9V	Buy & Sell	Toys & Games	5-Dec
K9V	Jobs	Office Manager & Receptionist	5-Dec
L4H	Real Estate	Rentals	5-Dec
L6Y	Community	Volunteers	5-Dec
N6K	Community	Rideshare	5-Dec
K1G	Community	Rideshare	7-Dec
M1P	Real Estate	Short term rentals	7-Dec
L1V	Pets	Birds for rehoming	7-Dec

N3L	Community	Friendship & Networking	7-Dec
N2L	Community	Missed Connections	7-Dec
N3L	Community	long lost relationships	2-Dec
N1R	Buy & Sell	Free stuff	2-Dec
M1B	Community	Volunteers	2-Dec
P1P	Services	Food and Catering	2-Dec
M1B	Buy & Sell	Free stuff	2-Dec
L6Y	Buy & Sell	Other	2-Dec
N1S	Buy & Sell	Free Stuff	4-Dec
M1B	Services	Health and Beauty	4-Dec
L9C	Community	Volunteers	4-Dec
M2M	Community	Friendship and Networking	4-Dec
L2E	Services	Entertainment	4-Dec
L6X	Jobs	Part time & Students	4-Dec
M2M	Buy & Sell	Free Stuff	7-Dec
M1X	Services	Health and Beauty	7-Dec
L9G	Community	Volunteers	7-Dec
N6K	Services	Other	7-Dec

M1R	Buy & Sell	Clothing	7-Dec
L1N	Services	Health and Beauty	7-Dec
K0M	Buy & Sell	Free Stuff	8-Dec
L0L	Services	Health Beauty	8-Dec
K1R	Buy & Sell	Clothing	8-Dec
L6Y	Community	Volunteers	8-Dec
M1V	Jobs	Other	8-Dec
N1E	Services	Childcare and Nanny	8-Dec
N6M	Services	Health and Beauty	18-Dec
N6L	Community	Friendship and Networking	18-Dec
M8V	Services	Wedding	18-Dec
L9C	Community	Volunteers	18-Dec
L9C	Buy & Sell	Books	18-Dec
N4K	Services	Tutors & Languages	19-Dec
K6V	Community	Volunteers	19-Dec
K6V	Community	Volunteers	19-Dec
L6A	Community	Volunteers	19-Dec
K0A	Community	Volunteers	19-Dec

K9V	Buy & Sell	Clothing	21-Dec
K6V	Pets	Accessories	21-Dec
L6A	Community	Activities & Groups	21-Dec
K0A	Pets	Accessories	21-Dec
L4A	Community	Rideshare	21-Dec
K6V	Buy & Sell	Free Stuff	22-Dec
L9G	Buy & Sell	Clothing	22-Dec
M1R	Community	Other	22-Dec
K1R	Community	Friendship & Networking	22-Dec
L6Y	Pets	Found	22-Dec
K0M	Buy & Sell	Free Stuff	27-Dec
L6X	Community	Missed Connections	27-Dec
M8V	Services	Other	27-Dec
N2L	Community	Volunteers	27-Dec
N3H	Buy & Sell	Clothing	27-Dec
K1G	Community	Friendship and Networking	27-Dec
A0A	Buy & Sell	Art & Collectibles	9-Jan
A1V	Services	Other	9-Jan

B3H	Buy & Sell	Free stuff	9-Jan
E2L	Volunteers	Community	9-Jan
G0J	Buy & sell- Clothing	Womens dresses	9-Jan
L1K	Community	Volunteers	12-Jan
E1A	Buy & Sell- Clothing	Womens Shoes	12-Jan
E3V	Community	Activities & Groups	12-Jan
C0A	Community	Freindship & Networking	12-Jan
G0G	Community	Volunteers	12-Jan
G4R	Community	Volunteers	12-Jan
J0G	Jobs	Other	12-Jan
H1A	Community	Volunteers	12-Jan
J8X	Community	Volunteers	12-Jan
A1V	Jobs	Construction and Trades	28-Jan
L96	Real Estate	Houses for Sale	28-Jan
J1S	Buy and Sell	Books	28-Jan
K9V	Community	Rideshare	28-Jan
K9H	Real Estate	For Rent	28-Jan

K9V	Real Estate	For Sale	30-Jan
N8H	Pets	Animal and Pet Services	30-Jan
N4T	Community	Sports Teams	30-Jan
N3H	Community	Missed Connections	30-Jan
N2L	Buy & Sell	Books	30-Jan
K4C	Community	Volunteers	30-Jan
K0A	Buy & Sell- Baby Items	Other	30-Jan
K0B	Buy & Sell-	Free Stuff	30-Jan
K0C	Community	Volunteers	30-Jan
K1G	Community	Friendship and Networking	30-Jan
K1G	Buy & Sell	Free Stuff	30-Jan
L6Y	Services	Health and Beauty	30-Jan
L4H	Community	Volunteers	30-Jan
L6A	Jobs	Other	30-Jan
N2L	Pets	Fish for Renting	1-Feb
N1L	Vacation Rentals	Ontario	1-Feb
N7G	Buy and Sell	Audio	1-Feb

N5X	Buy and Sell	Clothing	1-Feb
N4X	Real Estate	For Rent	1-Feb
N1H	Pets	Livestock	3-Feb
N6B	Community	Volunteers	3-Feb
N4T	Community	Other	3-Feb
N3L	Buy and Sell	Free Stuff	3-Feb
N2L	Real Estate	For Sale	3-Feb
N7S	Pets	Livestock	5-Feb
N8W	Buy & Sell	Books	5-Feb
N9G	Pets	Lost and Found	5-Feb
N9E	Vacation Rentals	Mexico	5-Feb
N1T	Cars and Vehicles	Automative Services	5-Feb
K0E	Community	Volunteers	5-Feb
K0G	Buy & Sell	Books- Other	5-Feb
P1L	Buy & sell- Clothing	Womens dresses & skirts	5-Feb
L7A	Community	Volunteers	5-Feb
N3A	Community	Volunteers	5-Feb
N7G	Vacation Rentals	Canada	6-Feb

N9Y	Pets	Livestock	6-Feb
N8H	Real Estate	For Rent	6-Feb
N2J	Community	Rideshare	6-Feb
N1E	Community	Volunteers	6-Feb
L6Y	Community	Volunteers	6-Feb
M1B	Buy & Sell	Free Stuff	6-Feb
N0L	Community	Volunteers	8-Feb
M2A	Community	Other	8-Feb
N0M	Buy and Sell	Home-indoor	8-Feb
N9G	Real Estate	For Sale	8-Feb
N7S	Pets	Accessories	8-Feb
N4T	Pets	Accessories	13-Feb
N3L	Community	Rideshare	13-Feb
N2J	Cars and Vehicles	Other	13-Feb
N3S	Buy & Sell	Computers	13-Feb
N1R	Buy & Sell	Furniture	13-Feb
N0H	Buy & sell- Clothing	Costumes	16-Feb
P0L	Services	Fitness & Personal Trainer	16-Feb

L1E	Buy & Sell	Free Stuff	16-Feb
L9H	Community	Volunteers	16-Feb
N3B	Buy and Sell	Books	16-Feb
N7G	Community	Events	17-Feb
N9E	Services	Health and Beauty	17-Feb
N5X	Pets	Livestock	17-Feb
N4S	Buy & Sell	Free Stuff	17-Feb
N3Y	Services	Cleaners & Cleaning	17-Feb
N6A	Buy and Sell	Free stuff	21-Feb
K0A	Buy and Sell	Volunteers	21-Feb
N7S	Community	Free stuff	21-Feb
P0L	Services	Events	21-Feb
N5X	Pets	For Sale	21-Feb
N4S	Cars and Vehicles	Other	27-Feb
N3L	Community	Rideshare	27-Feb
N8N	Services	Health and Beauty	27-Feb
N2L	Buy and Sell	Clothing; Wedding	27-Feb
N1E	Jobs	Customer Service	27-Feb

P1L	Community	Volunteers	27-Feb
K6A	Buy & Sell	Books- textbooks	27-Feb
P8N	Buy & sell	Free Stuff	27-Feb
L2A	Buy & sell- Clothing	Women's Bags & Wallet	27-Feb
L3M	Community	Volunteers	27-Feb
N9G	Pets	Fish for Rehoming	28-Feb
N8N	Buy and Sell	Hobbies and Crafts	28-Feb
N6K	Services	Food and Catering	28-Feb
N8X	Community	Missed Connection	28-Feb
N3Y	Buy & Sell	Clothing; Maternity	28-Feb
M1B	Community	Volunteers	28-Feb
L6Y	Services	Health and Beauty	28-Feb
N1E	Buy and Sell	Free Stuff	28-Feb
P1B	Buy and Sell	Clothing Womens Dresses and Skirts	28-Feb
K0G	Community	Friendships and Networking	28-Feb
M1X	Community	Long-lost relationships	28-Feb
M4Y	Services	Skilled Trades	1-Mar

M7A	Vacation Rentals	Canada	1-Mar
N3Y	Real Estate	For Sale	1-Mar
N2E	Buy and Sell	Computers	1-Mar
N1S	Jobs	Healthcare	1-Mar
N8A	Cars and Vehicles	Heavy Equipment	3-Mar
N8H	Jobs	Customer Service	3-Mar
N3S	Community	Sports Teams	3-Mar
N7G	Cars and Vehicles	Other	3-Mar
N6H	Pets	Fish for Rehoming	3-Mar
N7S	Cars and Vehicles	Heavy Equipment	4-Mar
N1T	Community	Long-lost relationships	4-Mar
N3S	Services	Health and Beauty	4-Mar
N2R	Real Estate	Land for Sale	4-Mar
N6B	Services	Music Lessons	4-Mar
N8X	Pets	Livestock	7-Mar
N5Y	Cars and Vehicles	Heavy Equipment	7-Mar
N3R	Community	Lost and Found	7-Mar
N2G	Buy & Sell	Books-Magazines	7-Mar

N8N	Services	Wedding	7-Mar
N5Y	Services	Tutors and Languages	8-Mar
N9G	Services	Travel and Vacations	8-Mar
N2G	Buy and Sell	Business and Industrial-Storage Containers	8-Mar
N1R	Pets	Fish for Rehoming	8-Mar
N9Y	Pets	Birds for Rehoming	8-Mar
N9Y	Community	Events	20-Mar
N8Y	Pets	Livestock	20-Mar
N7G	Buy & Sell	Home-Indoor	20-Mar
N3S	Pets	Animal and Pet Services	20-Mar
N5X	Jobs	Childcare	20-Mar
N2J	Community	Volunteers	20-Mar
N3S	Vacation Rentals	Canada	20-Mar
N1E	Buy & Sell	Baby items	20-Mar
N0M	Pets	Birds for Rehoming	20-Mar
N7G	Buy and Sell	Men's Clothing	20-Mar
N6H	Pets	Accessories	21-Mar

N2H	Jobs	Childcare	21-Mar
L8P	Vacation Rentals	Ontario	21-Mar
N5Z	Pets	Other	21-Mar
N2L	Buy & Sell	Women-Wedding	21-Mar
N6G	Pets	Livestock	22-Mar
N7G	Community	Rideshare	22-Mar
N6A	Vacation Rentals	Canada	22-Mar
N7G	Buy & Sell	Clothing-Costumes	22-Mar
N7G	Cars and Vehicles	Other	22-Mar
N6H	Buy & Sell	Health & Special Needs	24-Mar
N6H	Community	Volunteers	24-Mar
N6H	Services	Entertainment	24-Mar
N6G	Pets	Accessories	27-Mar
N6G	Clothing	Baby items	27-Mar
N3S	Community	Events	27-Mar
N9G	Buy and Sell	Free Stuff	27-Mar
N9A	Vacation Rentals	Ontario	27-Mar
N8H	Pets	Fish for Rehoming	29-Mar

N4X	Community	Rideshare	29-Mar
N3Y	Buy & Sell	Baby items	29-Mar
N2J	Pets	Accessories	29-Mar
N7G	Buy & Sell	Furniture	29-Mar
N8W	Services	Wedding	31-Mar
N6G	Services	Food and Catering	31-Mar
N9A	Jobs	Childcare	31-Mar
N5Y	Pets	Animal and Pet Services	31-Mar
N1H	Buy & Sell	Hobbies and Crafts	31-Mar

Appendix C Survey

HEART- Baseline

Survey Flow

Standard: ID (3 Questions)

Standard: Demographics (13 Questions)

Standard: Scales (49 Questions)

Standard: End of Survey (1 Question)

Page
Break

Start of Block: ID

The Impact of a Self-Compassion Intervention on the Resilience and Mental HEAlth of Women in RelaTionships: The HEART Study

Thank you for your continued participation in this study.

Participant ID

Safe Browsing Protocol

We are concerned about your safety as your partner may become angry if they learn you are participating in this study. Below are some steps you can take to keep your participation in this study private:

A) Use a safe computer or device (one your partner does not have access to)

B) Use 'In-Private', 'Private', or 'Incognito' browsing

C) Delete your history once you close the window.

At the bottom of each page of the survey there is an 'Exit Survey' button that will take you to google.com. If you use this button you may want to delete your browsing history when it is safe to do so. If you need additional help, simply search 'Private Browsing' along with the name of your browser (for example, Chrome, Safari) in your search engine. You may (Clement et al., 2012; Hongo et al., 2021) if you wish to read it.

ID Please enter the same unique participant ID that you created during enrolment using the following information:

1) The last two letters of your last name
2) The last four numbers of your phone number
3) The first two letters of your birth month

Ex: Jane Smith, 613-123-4567, born in October would be: **TH4567OC.** Please use CAPITAL LETTERS. This is now your unique participant ID, please keep a record of it.

---

trash Thank you for your continued participation in this study. We ask you to please answer the following questions as honestly as possible. There are no right or wrong answers to any of the questions. Whatever you truly think or feel is the answer you should pick.

End of Block: ID

Start of Block: Demographics

trash **Demographics**

Thank you for your participation in this study. This survey consists of a short demographic questionnaire, followed by four separate questionnaires assessing self-compassion, resilience, mental health, and mental health service utilization. Please answer as honestly as possible. There are no right or wrong answers. Whatever you truly think or feel is the answer you should pick. *

age What is your age in years?

_____

ed What is the highest certificate, diploma, or degree that you have completed?

- o High school (1)
- o Some high school (8)
- o College or university (2)
- o Some college or university degree (3)
- o Advanced degree (i.e., Master's or Doctoral) (4)
- o Some advanced degree (i.e., Master's or Doctoral) (9)

- I prefer not to answer (5)
- Not listed (please specify): (6)

_____

eth What is/are your ethnic origin(s)?

Please note, ancestors may have Indigenous origins, or origins that refer to different countries, or other origins that may not refer to different countries. For examples, please refer to this list of ethnic or cultural origins. Please note that clicking this link will open a new tab in your browser by redirecting you to a Government of Canada website.

Please specify as many origins as applicable below:

_____

sexualo What is your sexual orientation?

- Bisexual (4)
- Gay (2)
- Heterosexual (3)
- Lesbian (1)
- Pansexual (5)
- Queer (6)
- Not listed (please specify): (7)

_____

- I prefer not to answer (8)

relstatus What is your relationship status?

- Single (1)
- In a relationship, but not married/common law/engaged (2)
- Married, common law, or engaged (3)
- Divorced or separated (4)
- Widowed (5)
- Not listed (please specify): (6) _____
- I prefer not to answer (7)

area What type of community do you live in?

- Urban (1)
- Rural (2)
- Unsure (3)
- I prefer not to answer (4)

child Do you have children?

- Yes (please specify how many, ex: "2") (1) _____
- No (2)
- I prefer not to answer (3)

living Who do you live with? Please select all that apply.

- I live alone (1)

- I live with my child(ren) (2)
- I live with my partner (3)
- I live with my partner and child(ren) (4)
- I live with people other than my partner/children (e.g., friends, roommates, or family) (5)
- Not listed (please specify): (6)

_____

- I prefer not to answer (7)

employ What is your current employment status?

- Employed full-time (1)
- Employed part-time (4)
- Unemployed (5)
- Casual and/or seasonal (6)
- Other (please specify): (8)

_____

- I prefer not to answer (9)

income What is your average annual income, including employment, government, government cheques, child support, and other sources of income?

_____

sources From what/which source(s) does your income come?

- Employment (1)
- Canada Emergency Response Benefit (CERB) (4)
- Disability/Ontario Disability Support Program (ODSP) (5)
- Other (please specify): (6)

_____

- I prefer not to answer (7)

strain Please select the extent to which you agree with the following statement: Over the past 18 months, the COVID-19 pandemic has caused me financial strain.

- Strongly disagree (1)
- Disagree (4)
- Neither agree nor disagree (5)
- Agree (6)
- Strongly agree (7)
- I prefer not to answer (8)

End of Block: Demographics

Start of Block: Scales

services Have you used any mental health services during the COVID-19 pandemic?

- Yes (1)
- No (2)
- I prefer not to answer (3)

Skip To: End of Survey If services = 2

Skip To: End of Survey If services = 3

CSQ **The Client Satisfaction Questionnaire**

Please respond to the questionnaire below regarding your experiences with mental health services during COVID-19. Mental health services range from pharmacotherapy and psychotherapy delivered in acute care settings to community-based mental health supports provided by shelters and community groups.

	Dissatisfied	Mildly satisfied	Satisfied	Very satisfied
How would you rate the quality of the service you have received? (1)	○	○	○	○
Did you get the kind of service you wanted? (2)	○	○	○	○

To what extent did the program meet your needs? (3)	○	○	○	○
If a friend were in need of similar help, would you recommend the program to him or her? (4)	○	○	○	○
How satisfied are you with the amount of help you have received? (5)	○	○	○	○

Have the services you received help you deal more effectively with your problems? (6)	○	○	○	○
In an overall general sense, how satisfied are you with the services you have received? (7)	○	○	○	○
If you were to seek help again, would you come	○	○	○	○

back to the service? (8)	

Page Break

BACQ

Barriers to Access to Care Questionnaire

Please respond to the questionnaire below regarding your experiences with mental health services during COVID-19. Mental health services range from pharmacotherapy and psychotherapy delivered in acute care settings to community-based mental health supports provided by shelters and community groups. When thinking about these questions try and think about all the mental health services during COVID-19.

	This has stopped, delayed, or discouraged me	This has stopped, delayed, or discouraged me	This has stopped, delayed, or discouraged me	This has stopped, delayed, or discouraged me

	NOT AT ALL	A LITTLE	QUITE A LOT	A LOT
Being unsure where to go to get professional care (1)	○	○	○	○
Wanting to solve the problem on my own (2)	○	○	○	○
Concern that I might be seen as weak for having a mental health problem (3)	○	○	○	○
Fear of being put in hospital against my will (4)	○	○	○	○
Concern that it might harm my chances when applying for jobs (If non	○	○	○	○

applicable, enter 'NA') (5)				
Problems with transport or travelling to appointments (6)	○	○	○	○
Thinking the problem would get better by itself (7)	○	○	○	○
Concern about what my family might think, say, do or feel (8)	○	○	○	○
Feeing embarrassed or ashamed (9)	○	○	○	○
Preferring to get alternative forms of care	○	○	○	○

(e.g. traditional / religious healing or alternative / complementary therapies) (10)				
Not being able to afford the financial costs involved (11)	○	○	○	○
Concern that I might be seen as ‘crazy’ (12)	○	○	○	○
Thinking that professional care probably would not help (13)	○	○	○	○
Concern that I might be seen as a bad parent (If	○	○	○	○

non applicable, enter 'NA') (14)				
Professionals from my own ethnic or cultural group not being available (15)	○	○	○	○
Being too unwell to ask for help (16)	○	○	○	○
Concern that people I know might find out (17)	○	○	○	○
Dislike of talking about my feelings, emotions, or thoughts (18)	○	○	○	○

Concern that people might not take me seriously if they found out I was having professional care (19)	○	○	○	○
Concerns about the treatments available (e.g. medication side effects) (20)	○	○	○	○
Not wanting a mental health problem to be on my medical records (21)	○	○	○	○
Having had previous bad experiences with	○	○	○	○

professional care for mental health (22)				
Preferring to get help from family or friends (23)	○	○	○	○
Concern that my children may be taken into care or that I may lose access or custody without my agreement (If non applicable, enter 'NA') (24)	○	○	○	○
Thinking I did not have a problem (26)	○	○	○	○
Concern about what my friends	○	○	○	○

might think, say or do (27)				
Difficulty taking time off work (if not applicable, enter 'NA' (28)	○	○	○	○
Having problems with childcare while I receive professional care (if not applicable, enter 'NA' (29)	○	○	○	○
Having no one who could help me get professional care (30)	○	○	○	○

Page
Break

trash

Mental Health Service List Questionnaire

Please respond to the questionnaire below regarding your experiences with mental health services during COVID-19. Mental health services range from pharmacotherapy and psychotherapy delivered in acute care settings to community-based mental health supports provided by shelters and community groups.

PHCP Primary Health Care Providers

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

UCC Urgent Care Clinic

- o Yes (What were the barriers, if any?) (1)

_____

- o No (2)
- o Needed, but could not access. (Why?) (3)

_____

ER Emergency Room

- o Yes (What were the barriers, if any?) (1)

_____

- o No (2)
- o Needed, but could not access. (Why?) (3)

_____

SS Shelter Services

- o Yes (What were the barriers, if any?) (1)

_____

- o No (2)
- o Needed, but could not access. (Why?) (3)

_____

phar Pharmacy

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

pol Police

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

MHC Mental Health Center

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

CL Crisis Lines

- Yes (What were the barriers, if any?) (1)
- No (2)

- Needed, but could not access. (Why?) (3)

_____

RS Religious services (priests, minister, rabbi, etc)

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why) (3)

_____

psy Psychiatrist

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

WCC Women Community Centers

- Yes (What were the barriers, if any?) (1)
- No (2)
- Needed, but could not access. (Why) (3)

_____

Couns Counselor

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

SG Support Groups

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why?) (3)

_____

oth Other (Please specify)

_____

oth1 Referring to your answer above

- Yes (What were the barriers, if any?) (1)

_____

- No (2)
- Needed, but could not access. (Why) (3)

_____

End of Block: Scales

Start of Block: End of Survey

trash Thank you for your participation. We will send the self-compassion exercises to your inbox as soon as possible.

End of Block: End of Survey

Thank you for participating in this survey.

The Women's Helpline is available to you should you need additional resources at 1-866-863-0511.

Consider deleting your internet browser history for your safety. You can use this link to find instructions specific to your browser.

Appendix D Letter of Information/Consent

The Impact of a Self-Compassion Intervention on the Resilience and Mental HEAlth of Women in RelaTionships: The HEART Study

Research Team:

Cara Davidson, BHSc, MSc, PhD Student, Western University

Katie J. Shillington, BHSc, MSc, PhD Student, Western University

Nokuzola Ncube, BHSc, Western University

Jennifer D. Irwin, PhD, Professor, Western University

Tara Mantler, PhD, Assistant Professor, Western University (Primary Investigator)

Thank you for your interest in participating in The HEART Study. Before you decide whether to participate, the researchers would like you to read some important information about the study.

Invitation to Participate

You are being invited to participate in The HEART Study; a study investigating the impact of a self-compassion intervention on the self-compassion, resilience, and mental health of Ontario women currently in romantic relationships.

Purpose of the Letter

The purpose of this letter is to provide you with information required for you to make an informed decision regarding participation in this research study.

Purpose of the Study

The primary purpose of this mixed-methods (survey- and interview-based) study is two-fold: (1) to assess the impact of a 1-month self-compassion intervention on the self-compassion, resilience, and mental health of women, over time, for those in non-abusive romantic relationships compared to those in abusive romantic relationships; and (2) to understand all women's lived experiences of self-compassion, resilience, and mental health. The secondary purpose of this study is to investigate the mental health service utilization of Ontario women currently in romantic relationships (abusive and non-abusive).

Eligibility Criteria

You are eligible to take part in this study if you:

- Identify as a woman
- Are currently in a romantic relationship
- Live in Ontario
- Are 18 years of age or older
- Have access to a safe computer and telephone number

Study Procedures

We are aiming to recruit 46 participants for this study. Interested women will click the link in the study advertisement which will bring them to the enrollment survey. In the enrollment survey you will be asked to: (1) confirm your eligibility through a series of screening questions; (2) consent to participate, and (3) create a unique participant ID, which will be used to link your data across time points. Upon confirming eligibility and providing consent, you will be asked to engage in as many self-compassion practices as often as you would like and as is safe for one month (e.g., https://self-compassion.org/category/exercises/#exercises; Neff, 2021). There are 8 self-compassion exercises and 18 mindfulness practices to choose from. You are free to select whichever exercises and/or practices you wish. You may access these resources by visiting the host website, https://self-compassion.org/category/exercises/. Participants are expected to access the exercises and practices independently throughout their participation.

Additionally, you will be asked to complete an online survey at four time-points: baseline, immediately following the intervention, and 3- and 6-months post-intervention. It is anticipated that each survey will take approximately 30 minutes to complete. You will be able to complete the survey on your own time at a location of your choice (where internet is available). Upon completion of the baseline survey, you will be asked to submit your email address. Your email address will strictly provide you with a list of self-compassion exercises and guided contact you at follow-up time points; it will not be linked to study data. Additionally, we will be conducting interviews with approximately 12 participants. The interviews will last a maximum of 60 minutes and will serve to understand the impact of the intervention on women's lived experiences of self-compassion, resilience, and mental health. Those interested in participating in an interview will be asked to indicate such in the immediate post-intervention survey. Please note that not all individuals who express interest will be contacted for an interview.

Potential Risks & Benefits

The risks of taking part in this study are moderate. It is possible you may find it distressing to respond to questions about your personal history and your relationships. You will be asked about any potential experiences of violence in your relationships. If your abuser/partner sees you completing the survey, this may put you at increased risk. If this happens, we encourage you to connect with the Assaulted Women's Helpline at 1-866-863-0511.

Several safety precautions have been included in the survey. A safe browsing protocol will be provided to you at the beginning of the survey if you wish to use it. Also, an "Exit Survey" button is presented at the bottom of each survey page and can be clicked at any time to redirect you to a blank Google page.

By completing this survey, you are contributing to our efforts to understand the impact of a self-compassion intervention on women in relationships. It is anticipated that the self-compassion intervention will improve the mental health, resilience, and self-compassion of participants. However, it is possible that you may not directly benefit from participating in this research.

Compensation

Upon completion of each survey, you will receive a $5 honorarium (provided via Amazon e-gift-card) to recognize your time and contributions. Surveys will be made available at four timepoints: baseline, immediately post-intervention, 3-months post-intervention, and 6-months post-intervention.

Voluntary Participation

Participation in this study is completely voluntary. You do not waive any legal right by participating in this study. If you feel hesitant or uncomfortable answering some questions, you can refuse to answer those specific questions or end the survey at any time. You may request to withdraw your information up until the point of data analysis.

Confidentiality

Your survey responses will be collected through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. The data will then be exported from Qualtrics and securely stored on a Western University server behind institutional firewalls. Study data will be de-identified in the study database and direct personal identifiers will be retained in a master list, stored separately from the study database. Any identifiable study information (e.g., master list, email addresses, etc.) will be stored on an institutional drive and will be accessed remotely (via Western's Microsoft Teams) by the research team. All data collected will remain confidential and accessible only to the investigators of this study. While we do our best to protect your information, there is no guarantee that we will be able to do so. We are collecting some sensitive information. For example, email addresses are being requested for those interested in participating in a follow-up interview, as women will be contacted if they are invited for an interview. Further, should you choose to conduct the interview via the telephone, you will be asked to provide your phone number. Your phone number will be stored on a master list and will strictly be used for contact purposes (i.e., it will not be linked to study data). We are also collecting demographic information (e.g., age, sex, gender, ethnicity, geographic area, marital status, employment status, income, etc.). These identifiers will be collected for the purposes of descriptive statistics and understanding the population/cohort that is being studied.

After a minimum of 7 years, all data will be destroyed, including the master list of participant IDs. By participating in this research, you agree that the results may be used for scientific purposes, including publication in scientific journals. No individual information will be reported unless you agree to the use of unidentified quotes obtained during the study to be used in the dissemination of this research. Only group-level and aggregated data will be reported.

Contacts for Further Information

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact Dr. Tara Mantler

If you have any concerns about the conduct of this study or your rights as a research participant, please contact The Office of Human Research Ethics, Western University:

Phone: Email:

Eligibility and Consent

Prior to participating in this study, you will be asked to give consent and confirm your eligibility. If you do not provide consent, you will not be able to proceed to the survey. Further, submitting the survey is an indication of your consent to participate in the study.

Appendix E Demographics

Table 3. Demographic characteristics

Demographic Variable		Total
Sexual Orientation		
	Bisexual	11 (28.2)
	Gay	0 (0)
	Heterosexual	26 (66.7)
	Lesbian	1 (2.6)
	Pansexual	1 (2.6)
	Queer	0 (0)
	Not listed	0 (0)
	I prefer not to answer	0 (0)
Education Level		
	High school	6 (15.3)
	Some high school	0 (0)
	College or University	18 (46.2)
	Some college or university	6 (15.3)
	Advanced Degree	5 (12.8)
	Some advanced degree	4 (10.3)

	I prefer not to answer	0 (0)
	Not listed	0 (0)
Relationship Status		
	Single	7 (18)
	In a relationship, but not married/common law/engaged	17 (43.6)
	Married, common law, or engaged	14 (35.9)
	Divorced or separated	0 (0)
	Widowed	0 (0)
	Not listed	0 (0)
	I prefer not to answer	1 (2.6)
Type of Community		
	Urban	34 (87.2)
	Rural	3 (7.7)
	Unsure	2 (5.1)
	I prefer not to answer	0 (0)
Children		
	Yes	11 (28.2)
	No	28 (71.8)

	I prefer not to answer	0 (0)
Living Situation		
	I live alone	2 (5.1)
	I live with my child(ren)	0 (0)
	I live with my partner	11 (28.2)
	I live with my partner and child(ren)	2 (5.1)
	I live with people other than my partner/children (ie. Friend sor family)	11 (28.2)
	Not listed	1 (2.6)
	I prefer not to answer	0 (0)
Employment		
	Employed full-time	18 (46.2)
	Employed part-time	7 (18)
	Unemployed	4 (10.3)
	Casual and/or seasonal	3 (7.7)
	Other	7 (18)
	I prefer not to answer	0 (0)
	Not listed	0 (0)
Income		

	Employment	29 (74.4)
	Canada Emergency Response Benefit	0 (0)
	Disability/Ontario Disability Support Program	3 (7.7)
	Other	6 (15.3)
	I prefer not to answer	0 (0)
The COVID-19 pandemic has caused me financial strain		
	Strongly disagree	2 (5.1)
	Disagree	8 (20.5)
	Neither agree nor disagree	2 (5.1)
	Agree	17 (43.6)
	Strongly agree	10 (25.6)
	I prefer not to answer	0 (0)

Appendix F Responses of Barriers

Table 4. Responses of Barriers

Answers	**Total**
Availability (Hard to get an appointment; Appointments were being booked many weeks into advance; No beds available; The women's Collge Hospital Trauma Ttherapy group never called me back after they said they would consdier me for a second round of online support group therapy)	3 (15)
Wait times (longer wait times; Extremely long wait times; long lines, didn't answer phone, refills were done late, had to call several times about same prescription; Busy line!; longer wait times; Long waiting times because I had to use a state provided one for free; Longer wait times to see a professional; I tried to go to the Four Villages near my house)	8 (40)
Referrals (I don't trust my new doctor. and another doctor forced me to take pills that I hated the effects of; Sent me to see my family doctor;; They told me to go to the one that I went to years ago when I was working on my PhD, which is currently futher away	3 (15)

Service delivery (Not accepting in person appointments; Not sure How to access)	2 (10)
Cultural/Systemic Barriers	1 (5)
Financial (Difficult to continue - work insurance only allowed 2-3 follow up appointments to be covered, and it was too expensive for me to pay out of pocket for sessions after)	1 (5)
Other (NA,NA)	2 (10)

Appendix G Curriculum Vitae

Name: Nokuzola (Zola) Ncube

Post-secondary Education and Degrees:

Western University
London, Ontario, Canada
2015-2019 B.H.Sc

Western University
London, Ontario, Canada
2021-2023 M.Sc.

Honours and Awards:

Canada Graduate Scholarship
Canada Institute of Health Research
Western University
2022-2023

Province of Ontario Graduate Scholarship (Declined)
Western University
2022

Faculty of Health Sciences Deans Honour List
Western University
2017-2019

Western Heads East Global Opportunity Award
Western University
2018

Queen Elizabeth II Diamond Jubilee Scholarship
Western University
2018

Resolution Project Fellowship
The Resolution Project
2016

Take the Lead Scholarship
Brescia University College
2015

Academic Entrance Scholarship
Brescia University College
2015

Related Work Experience

Graduate Research Assistant
Western University
2021-Present

Graduate Teaching Assistant
Western University
2021-2022

Design Research Consultant
Deloitte
2022

Africa Research & Communications Fellow
mEducation Alliance
2021

Youth Engagement Associate
Plan International Canada
2019

Undergraduate Research Assistant
Western University
2018-2019

Social Business and Community Health Intern
Education for Better Living (Western Heads East)
2018

Empowerment Workshop Facilitator
Sexual Assault Centre of London (ANOVA)
2013-2014

Publications

Lesley Gittings, Nokuzola Ncube, Agnes Ronanc, Isobella Chimatirac, Luann Hatanec. Empowering and supporting frontline providers on the paediatric-adolescent HIV response: Results from participatory priority- setting and group discussions in twenty-four sites in twelve high HIV-burden African Countries. AIDS Care. Submitted.

Shillington, Morrow, D., Meadows, K., Labadie, C. T., Tran, B., Raza, Z., Qi, C., Vranckx, D. J., Bhalla, M., Bluth, K., Cousineau, T. M., Cunningham, D. E., Estrada, M., Massey, J., Ncube, N., & Irwin, J. D. (2023). Leveraging Kindness in Canadian Post-Secondary Education: A Conceptual Paper COPY CITATION TO CLIPBOARD. College Teaching, ahead-of-print. 1(8) http://dx.doi.org/https://doi.org/10.1080/87567555.2023.2181307 Accepted.

Cara A Davidson; Christina Safar; Julia Yates; Katie Jane Shillington; Nokuzola Ncube, Mantler, Tara. (2023). Resilience Across the Life Course for Women Experiencing Intimate Partner Violence. Advances in Life Course Research. Submitted.

Mantler, T; Jackson,K; Baer, J; White, J; Ache, B; Shillington, K*; Ncube, N*. (2020). Changes in Care- A Systematic Scoping Review of Transitions for Children with Medical Complexities. Current Pediatric Reviews. 16(3)

Thesis/Dissertation

The influence of Education Policy on Sexual Reproductive Health Service Knowledge, Attitudes, and Utilization for Young People in Tanzania. (2019). University of Western Ontario. Bachelor's Honours. Number of Pages: 12 Supervisor: Dr. Tara Mantler