



NATIONAL  
**Center**<sub>on</sub>  
*Domestic Violence, Trauma, and Mental Health*

---

**COMMITTED TO SAFETY FOR ALL SURVIVORS:**

*GUIDANCE FOR DOMESTIC VIOLENCE PROGRAMS  
ON SUPPORTING SURVIVORS WHO USE SUBSTANCES*

---

**GABRIELA A. ZAPATA-ALMA, LCSW, CADC**

## **COMMITTED TO SAFETY FOR ALL SURVIVORS:**

### *GUIDANCE FOR DOMESTIC VIOLENCE PROGRAMS ON SUPPORTING SURVIVORS WHO USE SUBSTANCES*

---

**GABRIELA A. ZAPATA-ALMA, LCSW, CADC**

This publication is supported by Grant #90EV0437-01-00 from the U.S. Department of Health and Human Services, Administration for Children and Families, Family and Youth Services Bureau. Points of view in this document are those of the authors and contributors and do not necessarily reflect the official positions or policies of the U.S. Department of Health and Human Services.



**NATIONAL  
Center** on  
*Domestic Violence, Trauma, and Mental Health*

The National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) is one of four Special Issue Resource Centers funded by the U.S. Department of Health and Human Services, Administration for Children and Families, Family Violence Prevention and Services Program. NCDVTMH's mission is to develop and promote accessible, culturally responsive, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being. Our work is survivor-defined and rooted in principles of social justice.

NCDVTMH provides a comprehensive array of training, consultation, and resources to support domestic violence and sexual assault advocates and their partners in the health, mental health, substance abuse, legal, and child welfare fields as well as policymakers and government officials in improving agency and system responses to survivors of domestic violence and other trauma.

For more information, see [www.nationalcenterdvtraumamh.org](http://www.nationalcenterdvtraumamh.org).

### Preferred Citation

Zapata-Alma, GA. (2020). *Committed to Safety for ALL Survivors: Guidance for Domestic Violence Programs on Supporting Survivors Who Use Substances*. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH).

### Editing, Layout, and Design

By Tamar Westphal

## Acknowledgements

This work would not have been possible without the countless contributions of those who came before us. I would especially like to honor and express gratitude for Patti Bland, MA, CDP, Director of Substance Abuse Training and Technical Assistance at the National Center on Domestic Violence, Trauma, and Mental Health, and Dan Bigg, co-founder and Executive Director of the Chicago Recovery Alliance. May they rest in power. Their legacies live on in all of the lives they touched. We all carry forth their vision as we tirelessly strive towards justice and peace for all.

We stand on the shoulders of giants.

## Table of Contents

Introduction .....	5
Why Might Survivors Use Substances?.....	8
Supporting People Who Use Substances as Within an Accessible, Culturally Responsive, and Trauma-Informed (ACRTI) Approach .....	12
Organizational Policies and Practices that Promote Safety Within Program Settings .....	16
Understanding the Dimensions of Substance Use .....	24
Meeting People Where They Are .....	26
Resources that Support Safety, Healing, and Empowerment .....	30
Supporting Survivor Safety and Choice Within Substance Use .....	31
Overdose Prevention .....	49
Conclusion .....	57
Resources and References .....	58
Appendices .....	62
Appendix A: NCDVTMH’s Integrated Approach .....	63
Appendix B: Glossary of Terms .....	68
Appendix C: Myths and Misconceptions .....	69
Appendix D: Naloxone Instructions .....	71
Appendix E: Safer Bathrooms .....	73
Appendix F: Mutual Aid Resources .....	74
Appendix G: Information on Commonly Used Substances .....	75

## Introduction

Thank you for your dedication to supporting all survivors. The goal of this guide is to assist programs and advocates in supporting survivors who use substances by providing practical strategies embedded within an accessible, culturally responsive, and trauma-informed (ACRTI) approach. The National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH)'s understanding of the depth of this need is informed directly by survivors, advocates, program directors, and coalitions as well as by the research it has conducted over the past 15 years. Most recently, NCDVTMH surveyed domestic violence (DV) programs across states, territories, and tribal nations. Of the 527 programs that responded, 75% indicated an increased demand for substance use disorder treatment services from 2017 to 2019 (Phillips et al., 2019). While this guide makes reference to substance use disorder treatment, at times, the goal of this guide is to enable advocates to move beyond conversations about treatment. In the same way that DV advocacy is grounded in the ability to support survivors whether or not they have decided to or are able to leave an abusive relationship, this guide is a resource for advocates to be able to support survivors whether or not they have decided to or are able to stop using substances.

### Questions for Reflection and Discussion to Support Advocates and Organizations on this Journey:

- What personal and professional experiences have influenced my (our) views on substance use and people who use substances? How do these views show up in my advocacy (our program)?
- Why might survivors who use substances hesitate to access our program's support? What can we do, as a program, to enhance access?
- What happens to survivors (and their children) if they are barred entry to or discharged from our services due to their use of substances? How does this reduce or increase risks that they (and potentially also their children) face? How does this align with our mission and values?
- How do societal stigma and discrimination against people who use substances show up in our services? How could we enhance safety and equity for all survivors?

Most (if not all) DV programs and advocates want to support survivors who use substances, but many times feel they do not have the knowledge or resources to do so. The skills needed to support survivors who use substances may seem far removed from our daily advocacy work. Yet, the skills DV

advocates use every day to support survivors who are seeking safety and freedom from abuse parallel the skills that can help survivors to increase their self-determination and safety related to substances. This makes DV programs and advocates uniquely prepared and positioned to support survivors who use substances. The key to unlocking the application of the skills already used in daily advocacy work is to overcome the stigma our society places on substance use. Advocates can best support survivors who use substances by approaching their substance use in the same ways that other safety needs are approached – through empowerment-based voluntary services that offer assistance with survivors’ self-defined goals, increase access to resources, and support safety planning. This approach requires an openness to multiple pathways of healing and to partnering with survivors in genuine and creative ways. It often involves not knowing exactly what to do, and being aware of the discomfort that accompanies uncertainty – feelings that many of us know very well. This guide, in conjunction with NCDVTMH resources and support, is designed help domestic violence/sexual violence (DV/SV) programs expand their capacity to advocate for survivors who use substances and their children.

Even with the knowledge, skills, and resources to support survivors who use substances, many programs and advocates may wonder whether providing this kind of support falls outside the bounds of DV/SV advocacy. The knowledge and strategies presented in this guide all fall within an accessible, culturally responsive, and trauma-informed (ACRTI) approach to DV/SV advocacy. This becomes especially clear when faced with the reality of substance use coercion – the many ways abusive partners leverage substance use as a mechanism of power and control against survivors. Stigma associated with substance use contributes to the pervasiveness and effectiveness of this kind of abuse. Additionally, stigma has been found to increase health risks and internalized shame, which in turn drives riskier use (GCDP, 2012). Stigma has even been linked to the current overdose epidemic (Wakeman & Rich, 2018). An ACRTI approach both requires as well as supports the expansion of skills and services to support survivors who use substances, while actively fighting the stigma that is so often used against them.

## Information and Strategies Found in this Guide

**Why Might Survivors Use?** provides information on the many intersecting factors that contribute to survivors continuing to use substances, which can be helpful in understanding the links between substance use and domestic violence. This section also provides some tips for opening conversations about substance use within DV/SV settings.

**Supporting People Who Use Substances Within an Accessible, Culturally Responsive, and Trauma-Informed (ACRTI) Approach** roots this guide within NCDVTMH's ACRTI framework.

**Organizational Policies and Practices that Promote Safety Within Program Settings** provides concrete guidance on cultivating an ACRTI approach to substance use that promote safety within program settings for survivors who use substances, survivors who do not use substances, children, and staff.

**Understanding the Dimensions of Substance Use** provides a structure for unpacking the uniquely personal dynamics of substance use experiences, supporting deeper empathy, active listening, individualized approaches, and collaborative partnerships with survivors.

**Meeting People Where They Are** presents a framework for providing survivor-defined support that includes strategies for assessing where people are (in relation to their substance use) as well as guidance on what kinds of approaches and resources may be helpful based on where people are.

**Resources that Support Safety, Healing, and Empowerment** supports resource advocacy by reviewing the internal and external resources that promote healing and recovery for individuals who use substances, inviting programs to reflect on which resources are already available within their services, as well as which resources could be added or expanded.

**Supporting Survivor Safety and Choice Within Substance Use** provides a more in-depth method for supporting survivors to safety plan around their substance use, including creating a plan that reduces risks related to substance use while also supporting each survivor in their self-defined goals, including health, safety, and overall well-being for the survivor (and their family).

**Overdose Prevention** provides information and strategies to both support survivors in knowing how to prevent and respond to an overdose, and to prepare programs to prevent and respond to overdose within their program settings.

**Appendices** provide additional resources and information that can be helpful in supporting survivors who use substances and their families.



## Why Might Survivors Use Substances?

There are many complex and interwoven reasons that can contribute to a survivor using substances. Sometimes, it may even feel like a mystery to the person who is using, especially if they find themselves using in ways that don't align with their values and/or goals. Individuals are more likely to be able to reflect on, better understand, and talk about what contributes to their substance use when they experience us and our services as safe, trustworthy, non-shaming, and noncoercive. While every person's reasons for using are unique and dynamic, here are some interrelated issues to consider.

### Introduction to Substances

Many survivors (especially women) are introduced to substances by an intimate partner. Intimate partners play a large role in the initiation of substance use, as well as the escalation from initial substance use to a pattern of chaotic or problematic substance use (Roberson, 2017; Amaro et al., 1995; Macy et al., 2013; Rothman et al., 2018; O'Brien et al., 2016). Studies have shown that over a quarter of survivors have experienced pressure or coercion to use from a partner or ex-partner (Warshaw et al., 2014). This is one of the many abusive tactics common to *substance use coercion*.

### Substance Use Coercion

Substance use coercion refers to the coercive tactics used against a survivor related to their history of substance use as part of a broader pattern of abuse and control. Examples of coercive tactics include introducing someone to substances in order to exert greater power/control over them, forcing someone to use substances (or use in a way that is unsafe or unwanted), sabotaging recovery efforts, and much more. A survivor may continue to use because of the ways a partner or ex-partner makes it dangerous or difficult for them to stop using. For more information, please check out the following resources posted on our website (<http://www.nationalcenterdvtraumamh.org>). *Mental Health and Substance Use Coercion* (Warshaw, Lyon, Bland, Phillips & Hooper, 2014) and *Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit* (Warshaw & Tinnon, 2018).

### To Numb Pain, Experience Joy, and/or Experience Connection

Survivors may use in order to numb emotional and/or physical pain related to domestic violence (Warshaw et al., 2014), other traumatic experiences, and/or health conditions (Bernardy & Montaña,

2019). Many survivors may avoid seeking medical attention for injuries they've endured due to stigma, fear, and the isolation they experience as part of the pattern of violence and control by their abusive partner. This can lead to survivors using substances to manage their physical pain in the absence of proper medical care. On the other hand, survivors may use substances because they were prescribed pain medication by a physician upon seeking medical care for injuries and/or chronic pain due to domestic violence (Balousek et al., 2007). Nationwide increases in the prescribing of opioids is part of what has led to our nation's current overdose epidemic (Stumbo et al., 2017; Beaudoin et al., 2016). Experiences of pain and trauma can interfere with a person's positive experiences, including the capacity for joy and feeling connected to oneself and others (Eds. Van der Kolk et al., 2012). These are experiences that everyone wants and needs in their lives. Social connection is vital for healing and well-being and both domestic violence and substance use contribute to isolation. A survivor's substance use may be their attempt at a solution, which in turn, may have become problematic for them.

### To Avoid Withdrawal

Withdrawal occurs on a continuum ranging from none to mild to severe to life-threatening, depending on the substance involved as well as their pattern and history of use. Using alcohol as an example: some people will use alcohol and never experience withdrawal while others may experience a mild withdrawal ("hang-over"); some episodes of alcohol withdrawal can be so severe that without medical support, can result in death. The same is true for benzodiazepines (a class of medications used to treat anxiety). Withdrawal from heroin and other opioids can be excruciatingly painful and may be life threatening if the person has other health conditions or experiences generally poor health. People who experience moderate-to-severe withdrawal are likely to continue using if they don't have access to withdrawal management services. Withdrawal management ("detox") services are available in both inpatient and outpatient settings and are typically only provided for alcohol, benzodiazepines, and opioids. Women, in particular, tend to develop substance use disorders more quickly even when using less substances for shorter amounts of time. This can result in increased risk for experiencing withdrawal as well as greater physical and mental health consequences related to use (NIDA, 2019). Women can also experience increased risk for continued use due to more intense cravings (NIDA, 2019).

## Lack of Access to Needed Treatment Resources

Survivors experience many complex barriers to accessing effective treatment. In general, treatment is a scarce resource in many communities and can be difficult to access even when a person has health insurance and other financial resources. On top of all of the barriers that an individual may face in their attempt to access treatment, a survivor often faces added threats to their safety as their abusive partner (or ex-partner) attempts to interfere with their treatment and recovery. Treatment providers can be ill-equipped to meet the needs of people with experiences of DV, which can increase safety concerns. This, combined with the all-too-common burdens of lack of transportation, childcare, and other barriers that survivors often face, can make it especially difficult to access needed treatment resources. When treatment is hard to access and/or ineffective in meeting a person's needs, they are often left feeling like what's the use in trying to get help. While many people are able to make healthier choices about their substance use without ever accessing treatment, lack of access is a serious problem for those who do need it. It is not for us to decide whether or not someone "needs" treatment. Our role is to provide an opportunity for survivors to learn about their options and support their access to whichever services they choose.

## Conclusion

Ultimately, the only way to understand what is contributing to a specific individual's use is by **actively listening to them**. If it is safe for someone to talk about their substance use within our setting, conversations can be opened using statements that express empathy and neutralize shame, such as:

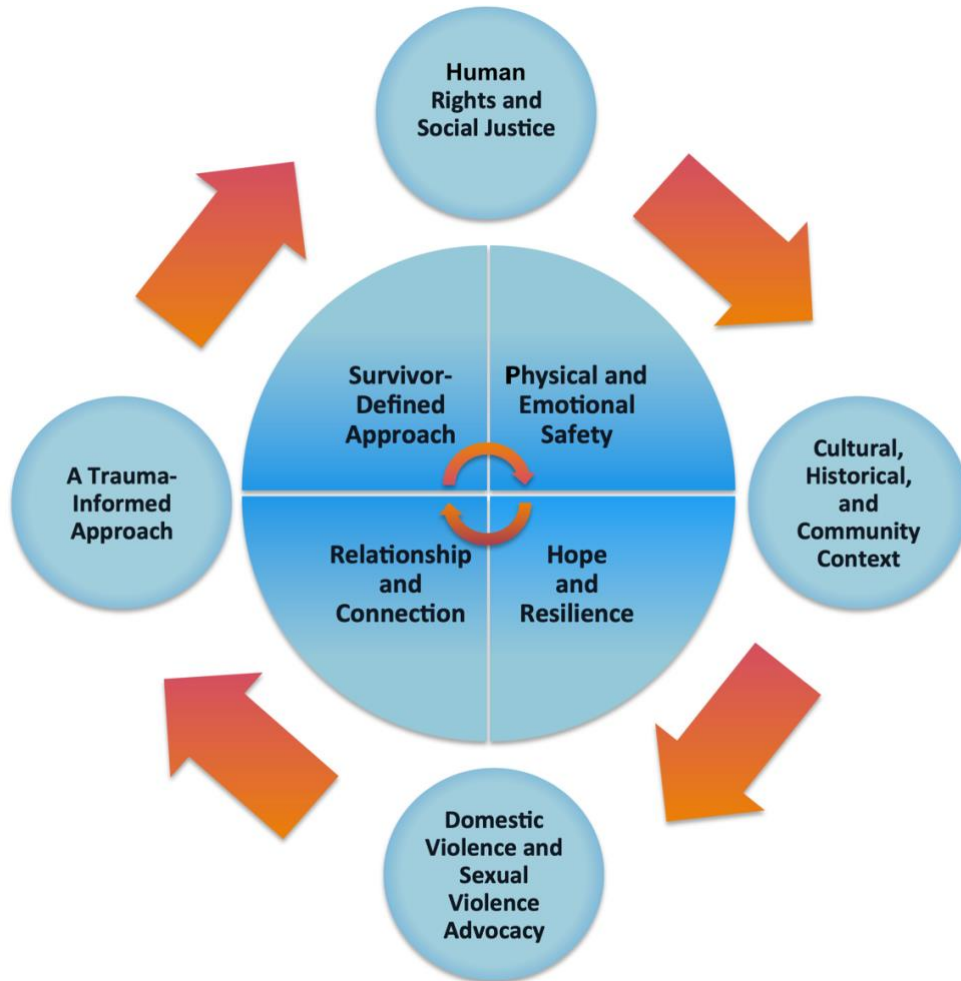
- "Many people have shared with us that their partner or ex-partner pressured them to use substances, or use in ways that they didn't want to. I wonder if you or someone you know has gone through this?"<sup>1</sup>
- "Sometimes people who have been hurt by a partner find themselves using substances to deal with the pain. This is a pretty common reaction. If this is something you can relate to, know that we're here to support you."

---

<sup>1</sup> For more tips on talking about substance use coercion, check out NCDVTMH's Toolkit on Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence (Warshaw & Tinnon, 2018). <http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a-toolkit/>

If someone feels safe enough to talk about their substance use within the program, it can also be helpful to ask about what the benefits of their substance use are: “People usually have their own reasons for using substances. What do substances help you with?”

Organizations and staff can create the supportive environment needed for a survivor to connect with their innermost thoughts, feelings, concerns, and wishes regarding their substance use. Connection, empowerment, and healing are nurtured when a person trusts that they will be truly *listened* to without judgment, without consequences, without attempts to persuade them, and with the full attention and support of their autonomy (as understood within a survivor-defined approach as “Recognizing and honoring each person’s right to define and determine what works for them and guaranteeing choice and control over their experiences...”<sup>2</sup>).



<sup>2</sup> From NCDVTMH’s Integrated Approach, found in Appendix A

## Supporting People Who Use Substances Within an Accessible, Culturally Responsive, and Trauma-Informed (ACRTI) Approach

The information presented in this guide is built upon an accessible, culturally responsive, and trauma-informed (ACRTI) foundation for supporting survivors who use substances.

Initially developed as a way to bridge trauma-informed and advocacy perspectives, this approach is grounded in domestic and sexual violence advocacy; incorporates an understanding of trauma and its effects; creates accessible environments for healing; recognizes the centrality of culture; attends to the well-being of staff, organizations, and communities; and is committed to social justice and human rights. The core principles of ACRTI work—physical and emotional safety, hope and resilience, relationship and connection, and a survivor-defined approach—provide a foundation for creating services that are welcoming and inclusive, attuned to the range of people’s experiences, and relevant to the people and communities we serve.<sup>3</sup>

An ACRTI approach is fundamental to creating the relational environment of emotional and physical safety that is necessary for supporting survivors, including survivors who use substances. NCDVTMH offers an array of resources to support organizations in deepening an ACRTI approach, including *Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations* (2018). For further information, NCDVTMH’s *Creating Trauma-Informed Services and Organizations: An Integrated Approach* has been included in the appendix.

### Accessible

Accessible services for people who use substances are necessary from both a perspective of safety, as well as human rights. Individuals do not lose their rights to safety and self-determination just because they use substances. Within this framework, substance use is approached in a matter-of-fact manner, with full knowledge that safety planning in the context of substance use requires the ability to move beyond condemning or ignoring an individual’s substance use. In practice, people are screened *in* to services based on need, rather than screened *out* due to recent or ongoing substance use. Substance use, like many other experiences, is multi-faceted and greatly influenced by internal and external factors.

---

<sup>3</sup> Warshaw, C., Tinnon, E., & Cave, C. (2018). *Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations*. National Center on Domestic Violence, Trauma, and Mental Health.

Creating greater accessibility for individuals with varying experiences of substance use involves seeking to better understand each survivor's experience from their perspective and appreciating that people have important reasons for using substances. When an individual's substance use seems to be in direct contrast to their goals, it becomes all the more important to seek an understanding of their experience of substance use, what benefits they experience from using, and what they would find helpful in support of their safety and well-being.

### Culturally Responsive

A culturally responsive approach recognizes the importance of social identity (age, gender identity, race, ethnicity, faith, sexual orientation, (dis)ability, language, country of origin, etc.) and positionality in shaping an individual's relationship with substance use and recovery. This involves an awareness that pathways of recovery are also deeply influenced by culture and positionality. So much so, that many individuals do not identify with concepts of "recovery" and instead connect with concepts such as healing; well-being; or reconnecting with community, family, and spirit (individual and/or universal).

A culturally responsive approach also recognizes that paradigms surrounding substance use and recovery have been historically based on male-centric and euro-centric narratives, which largely shapes the treatment and recovery landscape. For example, whereas traditional substance use treatment approaches have positioned concepts of "enabling" and "co-dependency" as integral to the understanding of substance use, a culturally responsive approach recognizes that everyone benefits from safe relationships and support. This framework brings an awareness of how "co-dependency" is a pathologizing term that has often been applied to individuals (particularly women) who have been financially isolated and oppressed as well as to those who nurture others because of their natural strengths and qualities and/or because that is the role society has demanded of them. Culturally responsive practice reclaims nurturing as a strength, not a liability, and recognizes the interdependence of all people while also being aware of how power dynamics lead to isolating and exploitative relationships that are never the fault of survivors.

The centering of mostly male and Eurocentric narratives within substance use treatment and recovery services has resulted in program models that often conflict with advocacy approaches, which leaves many survivors who use substances caught between fragmented services with no real access to resources or support. This becomes especially compounded for individuals from marginalized

communities, including people of color and people impacted by poverty, who are often subject to criminalization and harsher penalties while also experiencing discrimination and reduced access to resources that aid in recovery. The stigma associated with DV/SV is already multiplied if a survivor uses substances; this then becomes compounded when a survivor is also subject to structural violence including racism and/or poverty. These intersecting forms of marginalization and discrimination create complex threats to safety and recovery, which are then compounded by the lack of access to culturally responsive providers and services. All of this can form interlocking mechanisms of oppression that contribute to increased danger and worse outcomes, including mass incarceration of survivors of color (despite the same rates of substance use as white counterparts). Culturally responsive approaches for survivors who use substances endeavor to offer culturally resonant and humble services while also having an awareness of how interpersonal violence is inextricably tied to structural violence.

### Trauma-Informed

Trauma-informed approaches recognize the relationship between substance use, trauma, and domestic violence and integrates this knowledge into policies and practices while actively working to prevent retraumatization. Attempts to control an individual's decisions, including the decision to use substances, are avoided for many reasons. Attempts to control or pressure an individual replicate the power dynamics experienced in abusive relationships. Just as it is understood that a survivor is the expert on their relationship and that pressure to leave a relationship could actually increase their danger, a trauma-informed approach to substance use understands that the survivor is the expert on their life and that pressure to stop using substances is more likely to increase their risk. Instead, each person is embraced with support for their self-determination and unwavering respect for their dignity. This is based on a foundation of active listening to what survivors share, while deeply listening for what someone may feel but has not yet put into words. This is particularly important in supporting survivors who use substances, who are often blamed and shamed for the violence and substance use they have experienced. Trauma-informed approaches support the ability to hold multiple truths and appreciate multiple perspectives. Understanding the links between substance use, trauma, and domestic violence requires being open to the complex realities of how substance use can be used by abusive partners as a tool of abuse, while also helping survivors to cope with the abuse. The ability to hold these complexities is sustained within an organizational culture and structure that supports reflection and awareness of how one's past experiences are showing up in interactions with survivors.

Trauma-informed approaches include an awareness of what we, as individuals, bring to our interactions with survivors, as well as how we are personally impacted when we are truly open to the experiences of others. In the context of supporting survivors who use substances, this includes an awareness of what informs our norms, values, and perspectives in relation to substance use. This often includes our personal experiences and choices related to substance use, how our family, communities, and culture inform our perspectives on substance use, as well as any personal experiences of trauma or crisis that involved substances. This self-awareness is a necessary ingredient for reflective practice, which is supported by reflective supervision. Staff are able to create a healing environment for survivors when organizations are able to create a healing environment for staff, particularly in relation to the personal impact of the work.

## Summary

An ACRTI approach supports welcoming, inclusive, and effective services while enhancing awareness of how certain policies, practices, and program environments create barriers to safety for survivors who use substances. Rightfully so, many people who use substances experience fear in accessing services because of the history of rejection and criminalization based solely on their substance use. Reviewing existing policies and practices using an ACRTI lens is integral in continuing to cultivate organizational capacity to support survivors who use substances. The next section presents a selection of ACRTI organizational policies and practices that are fundamental to supporting safety for survivors who use substances, as well as safety within programmatic communities and settings.



## Organizational Policies and Practices that Promote Safety Within Program Settings

Programs can have the greatest impact by creating and adjusting policies and practices that dispel stigma and promote safety for all survivors, their children (if any), and staff. Everyone's safety is supported when programs are able to create an environment where survivors can safely talk about substance use with staff. When people are in an environment where they need to hide their use, this shuts down opportunities for staff to offer support with safety planning around use. This, in turn, increases risks for all survivors, their children, and staff. Listed below are examples of an ACRTI approach to policies and practices that support community health and safety within programs.

**Policy:** DV services are fully accessible regardless of a person's substance use.

**Practice:** Survivors are neither expected nor required to disclose their substance use to staff.

Instead, staff focus on setting the stage for safe conversations about substance use by:

- Building a supportive relational environment,
- Clearly communicating the limits of confidentiality (including any mandated reporting requirements),
- Normalizing that experimenting with or using substances is a common reaction to experiencing violence and coercion,
- Modeling matter-of-fact, empathic, and nonjudgmental approaches to substance use,
- Avoiding the use of confrontational approaches,
- Expressing that staff are available to listen and support if/when a survivor would like to talk about their experience with substances.

**Practice:** Programs have clear and concise policies regarding substance use (including guidelines about the possession and use of substances on-site).

- Policies are communicated in language that is understood by the survivor (both verbally and in writing).
- Policies are clearly connected to creating an environment of safety (i.e. policies focus on safety, not changing or controlling a survivor's choice to use substances).

- Survivors are included in cultivating an environment of safety (i.e. safety is not something that only staff provides for the program; rather, everyone has a role in creating a safe environment).

**Practice:** Programs do not impose artificial consequences for substance use.

- Substance use in and of itself isn't cause for service restriction or program exit.
- Programmatic consequences for substance use are experienced as punitive and contribute to harmful dynamics of power and control within advocacy relationships.
- When a survivor who uses substances experiences a natural negative consequence associated with use (such as being denied employment due to testing positive on a drug test as part of a hiring process), advocacy staff provide empathetic and nonjudgmental support to the survivor in ways that the survivor defines as helpful. This fierce alignment with a survivor who is experiencing harms related to substance use provides the kind of space and support they need to be able to consider decisions about how to improve their situation.

**Practice:** Programs have clear protocols for trauma-informed crisis prevention and response. Staff feel supported and comfortable in implementing established protocols during times when a survivor needs staff assistance in maintaining safety (whether or not substance use is involved).

- Programs can help prevent crisis by creating stable access to food and water. Certain medications and/or medical conditions may require eating outside of established mealtimes. Regardless of substance use, having the ability to satisfy one's hunger or eat for general well-being is essential to a sense of safety. This is especially important to a person's safety and well-being when they are using substances.
- If there is a specific behavior that is creating a safety concern within the program, staff offer support around the specific behavior (rather than focusing on whether or not substance use is involved).
- Staff partner with each survivor in creative and flexible solution-finding to support them in addressing the behavioral concern. If a survivor seems to be experiencing emotional dysregulation, staff engage with them in a soothing environment and offer self-soothing and co-regulation strategies.
- Once the immediate safety need has been resolved, staff debrief with each survivor, seeking their input on what happened, responding with empathy, and offering support to collaboratively craft solutions that can address their personal needs as well as the program community's safety needs.

- If a child welfare report is required, use as much transparency as possible, and give the survivor the choice to be present and involved in making the report.
- As advocates, it is important to recognize that punitive approaches are never warranted. Instead, to offer support and resources. It may be helpful to approach situations with the perspective that someone is experiencing a need (versus breaking a “rule” or doing something wrong). For more information, please see NCDVTMH’s online webinar series [Trauma-Informed Responses to Emotional Distress and Crisis](#).

**Policy: Services are provided on a voluntary basis.**

**Practice:** Survivors are supported in selecting what services they would find helpful (if any) and decide the timing and pace of services. In the context of substance use, this means:

- Service offerings are responsive to each survivor’s self-identified needs and concerns.
- Programs focus on building opportunities for peer support.
- Services are provided as flexibly as possible.
- Staff use creativity in partnering with survivors to collaboratively craft options based on survivors’ self-defined needs and preferences.
- Programs create access to non-stimulating safe areas for quiet time, reflection, and recuperation.
- Individuals are not compelled or pressured to engage in substance use treatment or any other recovery service that is not of their choosing.
- DV services continue to be accessible for a survivor regardless of whether or not they engage in any substance use treatment or recovery services.
- Staff offers information and resources that supports survivors with safety planning in regards to their substance use.
- Staff offers support for survivors in caring for and protecting their children, including safety planning in regards to substance use, and planning for children’s well-being.
- Legal advocacy services include child welfare advocacy (when desired).

**Practice:** Program offers a range of services that are responsive to diverse experiences of substance use and recovery.

- Staff offers support, resources, and empathic responses when survivors who identify as being in recovery and/or sober experience cravings to use or feel distress in regard to someone else's substance use.
- Program provides support groups that honor and respect the diversity of recovery goals, ranging from safer use to complete abstinence from all substances.
- Staff are trained on overdose prevention and response and overdose prevention education and materials are offered to all survivors.
- Program makes naloxone kits available in communal areas as well as has them easily accessible in staff areas (similar to fire extinguishers and first aid kits).
- Program is aware of safer bathroom practices and makes these accommodations as they are able to (see appendix for more information).
- Staff are knowledgeable of and able to collaborate with peer-led mutual aid groups and recovery community organizations. If desired by survivors, programs could consider having a well-vetted volunteer facilitate a mutual aid group on-site or can have a staff member trained to facilitate mutual aid groups (certain kinds of groups offer facilitator trainings, other groups must always be facilitated by a member of that mutual aid tradition). See appendix for more information and resources on mutual aid groups.
- If/when a survivor chooses to access substance use treatment and/or recovery services, staff provides information on available resources, advocates for access, supports active service connection and helps to anticipate and address any safety concerns that may come up in accessing these services. Safe and stable access to Medication Assisted Treatment (i.e. methadone, buprenorphine, etc.) is especially important for people with histories of opioid use.
- Program offers resources and support to facilitate adherence to treatment/recovery services and/or medication assisted treatment/recovery that survivors can request if they elect to access any kind of formal treatment/recovery resources.
- Staff has an understanding of how partners who seek to exert power and control over survivors often attempt to jeopardize a survivor's attempts to access formal treatment/recovery supports (including controlling access to medications) and offer support with strategizing safe ways to access treatment/recovery resources.

- Administrators and organizational leaders make efforts to increase access to substance use treatment and recovery services for survivors, exploring all available options. Partner with treatment providers to increase their awareness of the particular risks survivors face and to craft creative solutions including: telehealth for Medication Assisted Treatment (MAT) and other treatment services, advocating for survivors to pick-up methadone weekly and store their medication on-site (to avoid barriers to attending daily methadone services), and more. MAT programs are often concerned about misuse of medications used in addiction treatment, but are generally unaware of the risks survivors face from their abusive partners when MAT programs require attendance at routine (often daily) appointments. Collaboration, cross-training, and advocating within systems are all needed in order for survivors to be able to safely access treatment resources.

**Policy:** The program does not screen people for substance use (i.e. does not employ invasive screening procedures) and upholds survivors' right to privacy. No conditions or screening (aside from DV-related criteria) are required in order for survivors to receive DV services (including emergency shelter).

**Practice:** Organizations providing emergency shelter services provide residents with individual lockboxes where they can privately store personal belongings, including medications.

**Practice:** Organizations providing emergency shelter services avoid the practice of searching individuals' rooms or possessions. This kind of screening sets up a dynamic of staff being rule enforcers rather than advocates and supports and further reinforces the need for survivors to hide what they are going through.

**Practice:** Sharps containers are posted in bathrooms and other areas where people may need to self-administer injections. Many programs already have sharps containers for people who self-administer injection medications.

**Practice:** The program does not ask survivors to submit to drug testing at any point, for any reason.

- Mandatory drug testing is not aligned with an ACRTI approach and not considered an acceptable practice for DV programs. It is, in fact, harmful to survivors whether or not they use substances.
- Mandatory drug testing would not be aligned with current requirements for voluntary services, that expressly prohibit shelters from screening based on sobriety or requiring participation in services such as counseling as a condition for accessing emergency shelter, found in Family

Violence Prevention and Services Act (FVPSA) CFR 45 Part 1370. Additionally, transitional housing funded through the Office of Violence Against Women has a similar requirement that support services be voluntary (and not a condition for housing), found in 34 U.S.C § 12351 (b)(3)(C).

- According to the American Society for Addiction Medicine, drug testing should not be used as a tool of punishment or taking away privileges (ASAM, 2017).
- Mandatory drug testing is physically, emotionally, and socially coercive as well as humiliating. This practice implies that a person is only deserving of safety if they are free from substances AND that the assumption is that the person cannot be trusted to tell the truth, so they must surrender a bodily fluid in order to prove they do not use substances.
- The practice of mandatory drug testing can easily revictimize a survivor because of the ways it replicates substance use coercion.
- Drug testing is an imperfect tool at best and a coercive tool at worst. The only information a drug test can show is whether or not there is enough of a substance in a person's body for the test to detect. Drug test results do not reflect a person's pattern of substance use, says nothing about whether their substance use poses any risks, and cannot diagnose a substance use disorder (which is not within the purview of DV programs unless it is also licensed to provide treatment) (ASAM, 2017). There are times an individual may not test positive for substances but would qualify for treatment services (if they were interested in this resource).
- However, as long as there is no punishment or coercive practice associated drug testing, it can be helpful to have self-testing drug test kits available for those who request it. Some survivors may find it helpful to privately self-test as part of their preparation for job searching or court appearances.

### **For Programs that Require Drug Testing: An Invitation to Pause and Reflect**

If your program requires drug testing survivors, take some time to reflect on why that might be.

When did your program start drug testing? Has it always been this way?

Where did the idea of drug testing come from? Did someone believe it to be a best practice? If so, what informed this?

What function does it serve in your program?

1. To screen people out?
  - a. What kinds of support do you need to be able to shift from screening people out to screening people in to services?
2. To support recovery efforts?
  - a. Recovery is not produced by external control. What would it be like to offer rather than require?
3. To protect other residents?
  - a. How might stigma and bias show up here? How would drug testing be able to tell us whether someone may experience a crisis? Is this equating substance use with crisis? Drug testing is not a substitute for trauma-informed crisis prevention and response policies and skills.

### **Unique Considerations in Shelter and Other Congregate Living Settings**

A question that commonly arises is how a program can be most responsive when multiple survivors are using substances within a shelter program. This can present a complex situation that has many intersecting variables, including how the shelter is physically organized, the quality of interactions amongst residents as well as between residents and advocates, and what the existing expectations and guidelines are. All of the above listed policies and practices create a foundation for a program to be better positioned to respond to complex situations involving substance use. An ACRTI approach involves being able to work with survivors both individually and as a group within the shelter to facilitate survivor-designed solutions where everyone is involved in cultivating an environment of safety. Programs that

have been able to successfully navigate these kinds of situations have shared with us that a key element was developing an approach that facilitated peer-based support.

While this guide sets forth an ACRTI framework and strategies that supports advocates in both community and shelter settings to respond to needs of survivors who use substances, there are some more intricate situations (such as the one named above) that tend to come up more often in shelter settings. For this reason, we are creating a resource library that includes shelter-dedicated information and interviews with shelter programs to highlight best practices in responding to this and other shelter-specific questions (anticipated 2021).

## Conclusion

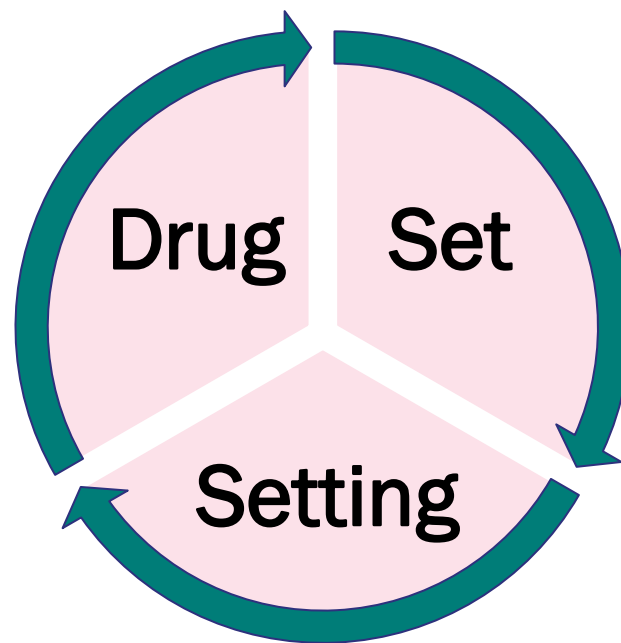
Ultimately, each organization must decide (and routinely review/update) their policies regarding the possession and use of substances on-site. These policies and their rationale can then be shared in a transparent, understandable, and empathic manner with survivors at program entry. If a survivor struggles with remaining within the boundaries of program policies, staff approach them with care and compassion, offering to help them craft solutions without fear of punishment or judgment. Our programs are safer when everyone is engaged as an equal partner in cultivating safety.

Rooted within this broader ACRTI empowerment framework and approach, the rest of this guide will focus on building our knowledge and skills to more effectively support survivors who use substances.



## Understanding the Dimensions of Substance Use

Experiences of substance use often vary and are influenced by three key factors (Zinberg, 1984). Recognizing these dimensions of substance use experiences not only supports our understanding of the factors that may be contributing to ongoing use but also help to support individuals in their process of self-exploration and in their consideration of multiple potential pathways for enhancing their safety and well-being.



**Drug:** The substance itself, route of administration, the amount used, and ultimately the chemical action it has on an individual's body (including their brain).

**Set:** The person's mindset and disposition prior to and during use, physical health conditions, cultural attitudes about use, rituals surrounding use, as well as their expectations of the substance use experience.

**Setting:** Environmental factors surrounding use, including time of day, location of use, how substances are obtained, social context of use, whether use needs to be hidden, socio-cultural factors, and more.

### Understanding the Dimensions of Substance Use: Cassie

Cassie recently entered a DV program's emergency shelter. When she first entered, she denied using any substances. As she grew more comfortable with staff, she shared that she uses cannabis daily to manage her feelings of stress, sadness, and loneliness and to help her sleep. She usually eats cannabis food before going to bed and finds that it helps with sleep and nightmares on most nights. Cassie shares that she will only vape cannabis when she is feeling particularly anxious or when she has trouble falling asleep despite having eaten cannabis, which ends up being 2-3 times/week. She usually feels relaxed and relieved after vaping, but avoids vaping cannabis because she knows she cannot vape in shelter and is afraid of being stalked, assaulted, or encountering legal problems when she vapes in a public area alone late at night. Cassie shares that she does not smoke cannabis due to her history of asthma. Cassie shares that she needs to find a job but is worried about being drug tested by potential employers. Otherwise, she is not concerned about her cannabis use and finds it to be a more "natural" way to cope than taking prescribed medication for anxiety or sleep. She gets along with most residents, but staff notice residents sometimes make snide comments if Cassie smells of cannabis or has reddened eyes.

**Drug:** Cannabis (eaten daily, vaped 2-3 times/week)

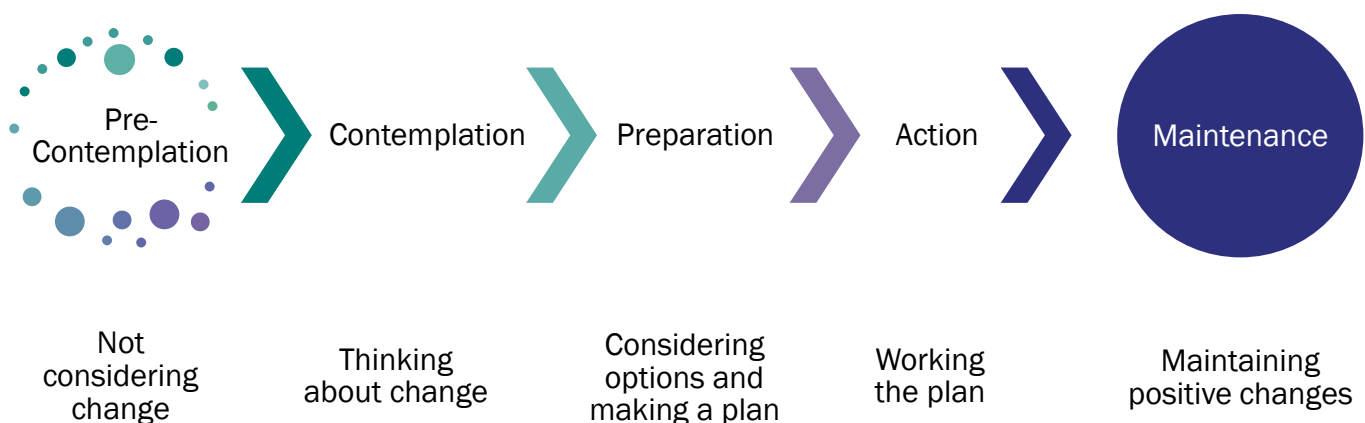
**Set:** Cassie feels anxious, stressed, sad, lonely and/or is having trouble sleeping prior to use. She feels relaxed when eating cannabis and it is part of her bedtime routine. She feels stressed while vaping cannabis in public areas because of her fear of being stalked, assaulted, or encountering legal problems. She expects to feel relaxed, relieved, and to be able to sleep after using. She has a history of asthma as well as trouble sleeping. She views cannabis as "natural" and preferable to medication.

**Setting:** Prior to the shelter, Cassie could eat and vape in her home with friends, without needing to hide her cannabis use. Now that she is in shelter, she is required to use in discrete and hidden ways. When she eats cannabis, it is typically at night as part of preparing for bed and she is in a safe location. When she vapes cannabis, she is usually alone late at night in different public environments, never staying anywhere too long for fear of being stalked, assaulted, or encountering legal problems. Cassie comes from a community that does not negatively judge cannabis use, but now that she is living in shelter, she experiences negative reactions from other residents.

Unpacking the dynamics of Cassie's relationship with cannabis can help us to collaborate with Cassie to increase her safety, while also respecting her autonomy and supporting her self-defined goals.

## Meeting People Where They Are

Meeting people where they are is essential for supporting survivors who experience harms related to their substance use, especially since a survivor may be using substances in order to cope with the trauma of abuse or to reduce danger from ongoing domestic violence. It can be hard to remain neutral when it seems like someone is experiencing harms related to substance use and they either don't see it the same way or don't feel that they can do anything about it. Yet, we know that imposing our own point of view isn't helpful and is more likely to replicate a survivor's experiences of an abusive partner who is controlling and limiting their choices. A head-on approach can have a shaming and alienating effect that can then lead to individuals hiding their substance use, mistrusting staff, and potentially avoiding advocacy services altogether. Instead, this approach to substance use parallels the approach that is taken to other safety needs: meeting the person where they are and offering the kind of support and resources that the person finds helpful. The Stages of Change model (Prochaska & DiClemente, 1983) offers a framework for recognizing where someone who experiences harms related to substance use may be in their own process of change, enabling providers to offer support that is attuned to where they are. That said, this model is not to be used in attempts to direct someone's decisions or applied to their choices regarding leaving or staying with an abusive partner.



Here are some examples of what a person may share and/or an advocate might notice at each stage:

Stage of Change	What someone might share and/or what may be noticed
Pre-Contemplation	The person is not considering any changes related to their substance use. They might not see any need to make changes to their substance use. If staff raises any potential need to change, the person may react negatively or feel coerced. The person may recognize the problems they are experiencing but feels hopeless that they can do anything about it.
Contemplation	The person is starting to consider whether changing something about their substance use might be helpful. It is common for a person to make statements for and against change and feel very stuck between whether or not to change. People can be in this stage for a long time.
Preparation	The person has decided they would like to change something about their substance use and intends to take action in the near future. They may be exploring options for how to approach change, experimenting with potential strategies, verbalizing their substance use goal(s) and seeking support and resources to support their goal(s). People often start taking some initial steps towards change during this stage.
Action	The person is actively taking steps towards their goal(s).
Maintenance	The person is integrating the changes they've made into their routine and day-to-day life. They're moving forward with their goal(s) and potentially taking on additional life goals.
Lapse	After a period of action or maintenance, the person is experiencing a return to something they previously found problematic or not aligned with their goal.

Prochaska and DiClemente's ground-breaking research found that **85-90%** of individuals who use substances are in *pre-contemplation* or *contemplation* stages while the majority of substance use services are designed to help the **10-15%** of individuals in an *action* phase of change. **This mismatch results in missed opportunities, discord in provider relationships, and negative outcomes.**

**Pause and Reflect: What stage of change are your services most geared towards? How are your services accessible and relevant for the 85-90% of people in earlier stages of change?**

It is common to feel unsure about how to offer help when someone isn't interested in or ready to make changes regarding substance use. This can leave everyone feeling stuck and frustrated. Instead of trying to persuade someone to change their substance use or getting tired and just avoiding the topic altogether, we can approach these moments as an opportunity to **slow down, reflect on where someone is telling us they are in their process, and think about how to better meet them where they are**. This requires us to be aware of what we bring to the interaction (our own history, feelings, values, and assumptions). The same skills advocates use to manage fears about the dangers a survivor may face become very important when managing feelings that may come up in relation to substance use. Reflective practice and supportive supervision (including peer supervision) are key elements in an ACRTI approach so that we can truly meet people where they are, rather than where we would like to be.

### Stages of Change: Cassie

**Pause and consider:** Based on the description of Cassie's views on her cannabis use (p. 25), in which stage of change do you think she might be?

**Stage of change and why:** Cassie is likely in a *contemplation* stage of change since she is comfortable with her use in general, but also thinking about how it may impact her job search as well as trying to avoid vaping because of safety concerns. There are some things about her relationship with cannabis that she finds useful and important as well as some things that might get in the way of her other goals. She is recognizing some of the pros and cons, and thinking about how cannabis might (or might not) fit in with her larger goals.

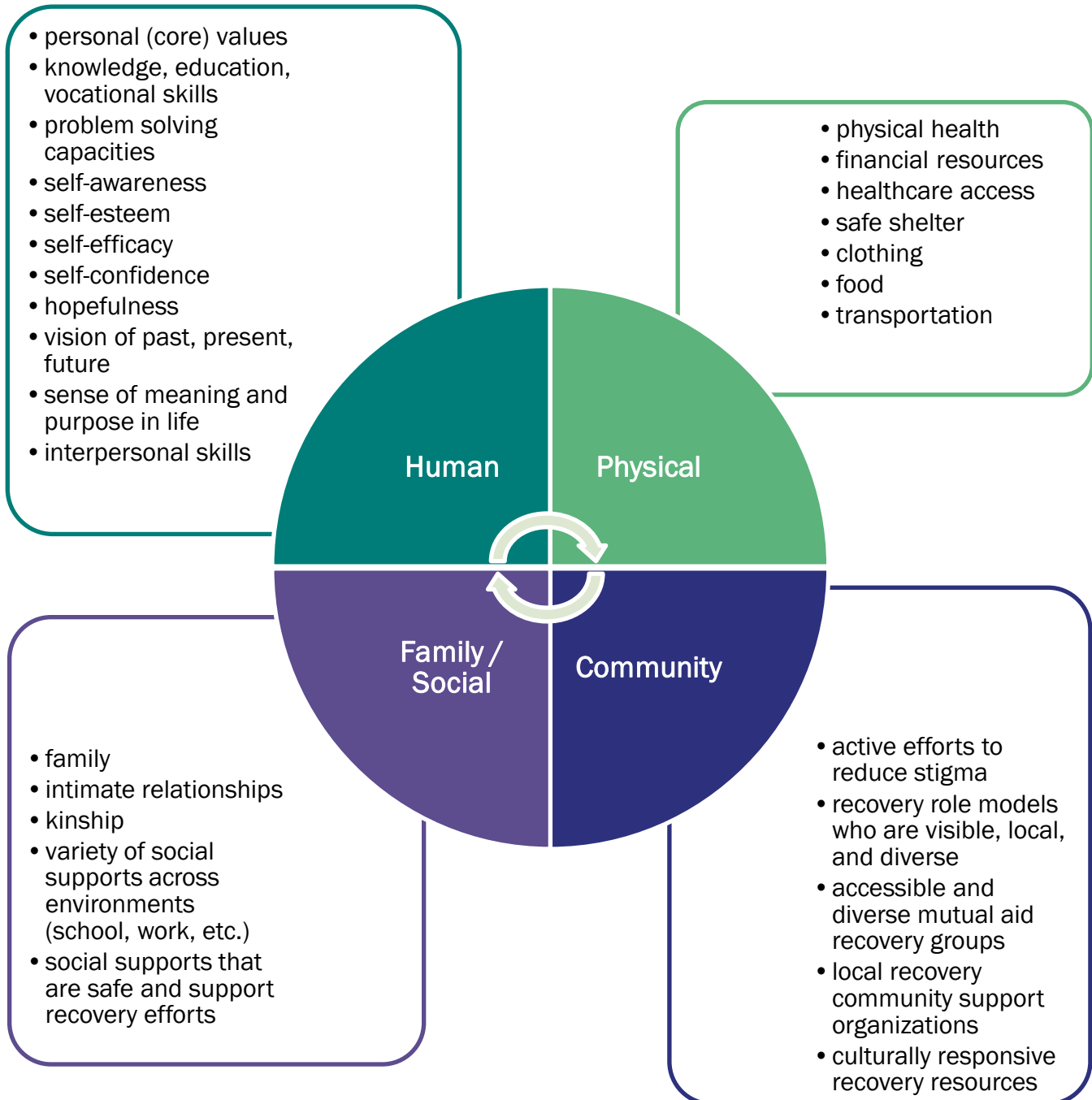
While there are many ways to provide support and resources at each stage, the table below illustrates some ways advocates can meet a person where they are in relation to their substance use.

Stage of Change	How Advocates Can Help
Pre-Contemplation	Build relationship. Focus on the person's self-defined needs. Help to establish basic safety and stability (including overdose prevention planning). Help with resources to address self-defined needs.
Contemplation	Gentle curiosity and reflective listening can help create a safe place for survivors to think about their experiences with substance use and consider their goals and priorities. Remain neutral regarding any potential change, or weigh in on the side of <u>no change</u> .
Preparation	Help to brainstorm options and craft potential solutions. Help to connect with resources that can support their goal(s).
Action	Affirm any positive step as defined by the individual. Normalize missteps. Help re-work potential strategies and solutions as needed.
Maintenance	Help to make any adjustments needed to maintain gains long-term.
Lapse	Provide emotional support and help neutralize any feelings of shame. Recognize their achievements along the way and affirm their ongoing commitment to their goal(s). Use as an opportunity to learn about what strategies/resources may have been missing and help refine strategies and connect with desired resources.

This research also found that as people make their own determinations about change, they do not simply move through these stages in a straight line and lapses or setbacks are common as people work towards their goals. It can be helpful for advocates to expect and embrace the fact that an individual's path is often filled with twists and turns. When staff feel particularly puzzled about how to be helpful and supportive for someone who is using substances, it can be very helpful to pause and reflect on where the person may be in their process of change. From there, it becomes easier to consider whether the services that are being offered are meeting the person where they are and brainstorm what else may be helpful given where the person is. While this framework is a useful tool in being able to meet people where they are, there are some skills that are universally important: relationship building, cultivating hope, safety planning, and resource advocacy.

## Resources that Support Safety, Healing, and Empowerment

In addition to meeting individuals where they are, access to resources is crucial. Advocates can actively support access to internal and external resources that help people establish safety and well-being (Recovery Capital by White & Cloud, 2008) while also recognizing how the lack of these resources contributes to people feeling stuck. Recovery resources fall along four major areas:



## Supporting Survivor Safety and Choice Within Substance Use

The same way that we continue to respect, support, and safety plan with an individual who is in an abusive relationship, we apply that same perspective and survivor-defined approach to supporting a person who continues to use substances. Substance Use Management (SUM) (Bigg, 2001) is a collaborative relationship-based model for supporting people who are currently using substances (including alcohol) to make self-defined positive changes that decrease their risk and increase their health, safety, and overall well-being as well as that of their family members. This approach calls upon many of the same skills used in empowerment models and safety planning for domestic violence. Plus, it does not require any formal credential or licensure to practice.

SUM focuses on an individual's preferences and goals, and supports any positive change the person is willing/able to make as they move towards their self-defined goals. As a result, individuals can develop a plan about their substance use that prioritizes their:

- Health,
- Responsible decision-making, and
- Overall well-being, including:
  - Stable housing,
  - Access to income,
  - Health care behaviors, and
  - Personal/family responsibilities.

Historically, “recovery” has been defined as life-long abstinence from all substances. This has led many providers to focus solely on the goal of abstinence and resources to achieve abstinence (such as treatment or 12-step groups). SUM honors and cultivates multiple pathways towards recovery, with a full understanding that long-term recovery becomes a reality when a person:

- Is respected in their decision-making,
- Feels a sense of connection,
- Has timely access to needed resources, and
- Their absolute worth and dignity as a person is honored within every aspect of programming, at every phase of their recovery journey.



## Our Role as Advocates

Advocacy seeks to come alongside survivors as a source of support. This can feel challenging in the context of substance use due to the pervasive messaging that total abstinence from substance use is the only measure of success. While many people may choose abstinence as their goal in this approach, our role is to support the person in defining for themselves whether and what changes to their substance use they would find helpful. Many times, an individual may not notice their progress towards their goal(s), especially when they are faced with overlapping experiences of stigma and abuse. It is common for someone to feel like they just “lucked into” a positive outcome. We can help a person to realize their own power by clearly connecting how their personal strengths and values underpin any positive changes they experience. These mini-wins build the momentum needed to take on larger goals.

## Four Main Steps in the Practice of Substance Use Management

### Step 1: Overcoming Decades of Expectation

The first step is to expand one’s own awareness of the many ways that people can improve their lives through their self-defined goals (which may or may not include abstinence from substance use). Moving beyond an all-or-nothing perspective is essential for the next step.

### Step 2: Creating an Environment for Free Choice

The second step is to create an environment that supports survivors in making their own decisions. This requires programs to recognize and resist any instinct to persuade someone in regards to their substance use, and instead, to focus on what they define as their needs, goals, and preferences.

One helpful strategy is to ask for an individual’s permission before engaging in a discussion about their substance use. This is best done by providing some context (i.e. what is the purpose of discussing substance use?) as well as transparency around confidentiality. We could say something like: “I’m hoping we can talk about substance use during our meeting today. That would help me get a better picture of what would feel most supportive for you. What we discuss is confidential [naming any exceptions to confidentiality]. Would that be alright with you?”

It is important to back off when someone tells us they don’t want to discuss their substance use; often, people need to see that we will respect their limits before being able to trust that they can open up to

us. We can ask if it would be alright to check in with them again in the future or invite them to bring it up with us if that would be helpful. In the meantime, we can focus on continuing to build relationship and supporting their self-defined needs.

### Step 3: Collaborating in Self-Defined Goals

Within an environment of free choice, advocates can offer encouragement to individuals as they consider their options and experiment with potential strategies to support their self-defined goals. If an individual struggles to come up with what they would find helpful, listed below are some ways we can support them to explore their ideas:

- Ask what they've tried in the past
- Talk with them about what they've found helpful (or not helpful) in the past
- Ask them what other people they know have tried
- With permission, offer examples of what we've seen other people in similar circumstances try.

If a survivor brings up aspects of their substance use they dislike, we can ask them about times when they don't experience these problems (or they are lessened). From there, we offer support by gently exploring what may contribute to them experiencing fewer problems in those moments. For this approach to be effective, it is important to keep the following in mind.

- The individual using substances is the one who defines whether there are any negative aspects to their use, and if so, what they are.
- Examples of what people may dislike about their substance use include:
  - Risks related to using substances,
  - How substance use interferes with other goals,
  - Uncomfortable aspects of intoxication and/or withdrawal,
  - Natural consequences associated with substance use,
  - Feelings associated with substance use (such as shame),
  - People or places associated with substance use, or
  - Substance use in of itself.

What matters most is that this is self-defined.

- The words “problem” or “problematic” may come across as shaming. It is important to tune into how someone describes their experience while avoiding the use of labels.

This empowerment-based approach positions advocates to support survivors in their choices while also using the advocacy skillset to explore options and connect with needed resources.

#### Step 4: Evaluating Impact and Reconsidering Directions

All of the previous steps form the necessary foundation for advocates to be able to support survivors in reflecting on what is and isn't working for them regarding their substance use. Based on this reflection and open discussion, advocates can support survivors in re-working their safety plans and refining the strategies that will support them in their goals.

As an individual accomplishes some of their initial goals (with us affirming *any positive change as defined by the person*), they generate momentum to tackle some of their larger goals. At the same time, as the individual has the support and freedom to reflect on what isn't working about their plan, they are able to arrive at potential solutions they may not have considered before. This is a natural and necessary part of the healing journey. Throughout this process, we continue to approach the person as the expert in their life, validating their perspective (everyone makes sense within their own context), and continue to help them recognize their own courage, worth, and power.

**Substance Use Management strategies often fall across the three major areas that influence the experience of substance use: drug, set, and setting. Here are some examples for each area.**

**Drug-Specific SUM Strategies:** Listed below are some examples of strategies related to substances themselves that survivors may want to try in pursuit of their overall goals. If prescribed medications are involved, strategies that modify any use of the prescription(s) will need to include the prescriber in consultation. In these kinds of situations, advocates can often help by supporting the individual in being able to have more open communication with their medical provider(s), as well as help them overcome barriers to accessing more effective medical care when needed. Please note in the case of opioids (including heroin), that tolerance will change if a person changes their pattern of use, which needs to be considered in overdose prevention safety planning (please see section on [Overdose Prevention](#) for more information).

- Reducing amount of substance used
- Reducing frequency of use
- Avoiding mixing substances (i.e. using more than one substance at the same time)
- Abstaining from one or more substances
- Changing to a less direct and/or risky route of administration (for example, changing from injecting to snorting)
- Better vein care (for those who inject substances intravenously)
- Safer injecting, snorting, and/or inhaling practices
- Substituting one substance with a less risky/problematic substance

**Set-Specific SUM Strategies:** In addition to supporting the individual’s physical health and self-care, this array of strategies depends largely on supporting the survivor’s self-exploration, self-reflection, and considering how the survivor’s insights inform their decisions of what kinds of strategies would be helpful in pursuit of their goals. This requires us to remain wholly aligned with the survivor, validating their experiences, perspectives, and attempts at solutions. Staff must resist any instinct to persuade the survivor of their own perspectives or solutions, and remain an emotionally supportive and gently curious ally in this process. Examples of set-specific strategies are listed below.

- Increasing healthy nutrition
- Wellness medical care
- Engaging in care for physical and/or mental health conditions
- Exploring a person’s frame of mind when they are seeking to use (are there certain frames of mind that lead to riskier or more chaotic use? What factors lessen risky or chaotic use?)
- Considering the benefits or function of their use (what do they hope for when they use? What does using help them with?)
- Exploring other (non-use) ways they experience that benefit/function – how can staff help them replace the benefits they are experiencing from using? (For example, if use helps them feel calmer, what are some other times they feel less stressed? How can the program support their self-soothing skills as well as access self-soothing?)

- Developing health-promoting rituals around use. Substance use tends to be ritualistic in nature, so we can help an individual to brainstorm actions they can add in their substance use routine that support their health. Some examples include drinking a cup of water with every alcoholic beverage or tying a tourniquet in a certain way so that it can be easily released (which can help reduce the risk of infection, injury, and overdose; please see appendix G for more resources on better vein care).
- Exploring a person’s experience of shame, and how that interacts with use. Shame often drives use, but can be neutralized by both destigmatizing use (i.e. taking a matter-of-fact approach to substance use), as well as building strong relationships that based on unconditional support for the person and their autonomy, respect, dignity, caring, and openness. One way to explore a person’s potential experience of shame around substance use is to start by normalizing the experience and then gently leaving an opening for the person to share their experience with us if they choose to do so. For example, “There’s a lot of stigma and shame that gets placed on substance use in our society, neither of which is fair or helpful. It’s really easy to get caught up in a cycle of shame and substance use. What’s been your experience?”

**Setting-Specific SUM Strategies:** These strategies focus on the social and physical environments where an individual obtains substances, uses them, and recovers from use. The main goals of these strategies are to support responsible decision-making and safety of the survivor, their children, and community members. Examples of setting-specific strategies are listed below.

- Separating use from other tasks (such as driving, work, family responsibilities, etc.)
- Creating a safer use environment by safety planning around:
  - Location of use
  - People who are around during use and/or with whom substances are used
  - How substances are obtained/stored
  - How paraphernalia are stored and disposed of
- Creating a plan for managing responsibilities during use and any recuperation period after use
- Relationship building, conflict resolution and/or mediation needs with safe social supports
- Overdose reversal training for social supports

### Substance Use Management: Victoria

Victoria is a 47-year-old woman who shared that she had experienced domestic violence and sexual assault. She drinks about 12 beers daily, usually starting in the morning. She does not eat regular meals and her prescribed medications include a benzodiazepine (a kind of anti-anxiety medication) for panic attacks. Victoria describes her current partner as “sweet” but that sometimes “he gets out of hand when he’s wasted, but it’s nothing [she] can’t handle.” Victoria reports her main concern is an ex-partner who continues to stalk her and recently attacked her as she was walking her dog near her home. She does not want any kind of legal intervention to address her ex’s ongoing abuse at this time, stating that she doesn’t think anyone will take her seriously because she’s usually been drinking when she’s attacked and she can’t remember many details. She shares that she sometimes drives when she is under the influence of alcohol. Victoria lives alone with her dog in a rural community, where her closest friend lives an hour away and her significant other lives two hours away. Victoria shares that her partner tends to visit about once a week and will stay at her home for 2-3 days at a time. When he is there, he makes them cocktails with hard liquor and encourages her to “keep up” with him. She isn’t sure exactly how much she drinks on days when he’s visiting. She usually ends up taking her prescribed benzodiazepine when he is there because she experiences more panic attacks when he stays over and she doesn’t want to give him a reason to call her “crazy” again, but this often means she becomes more intoxicated more quickly.

Let's first think about what we know about Victoria's situation using a Drug-Set-Setting perspective:

## Drug

- Usually drinks ~12 beers/day, starting in the morning
- Drinks unknown quantity of hard liquor 2-3 days/week when her partner is present, more likely to take her prescribed benzodiazepine on these days

## Set

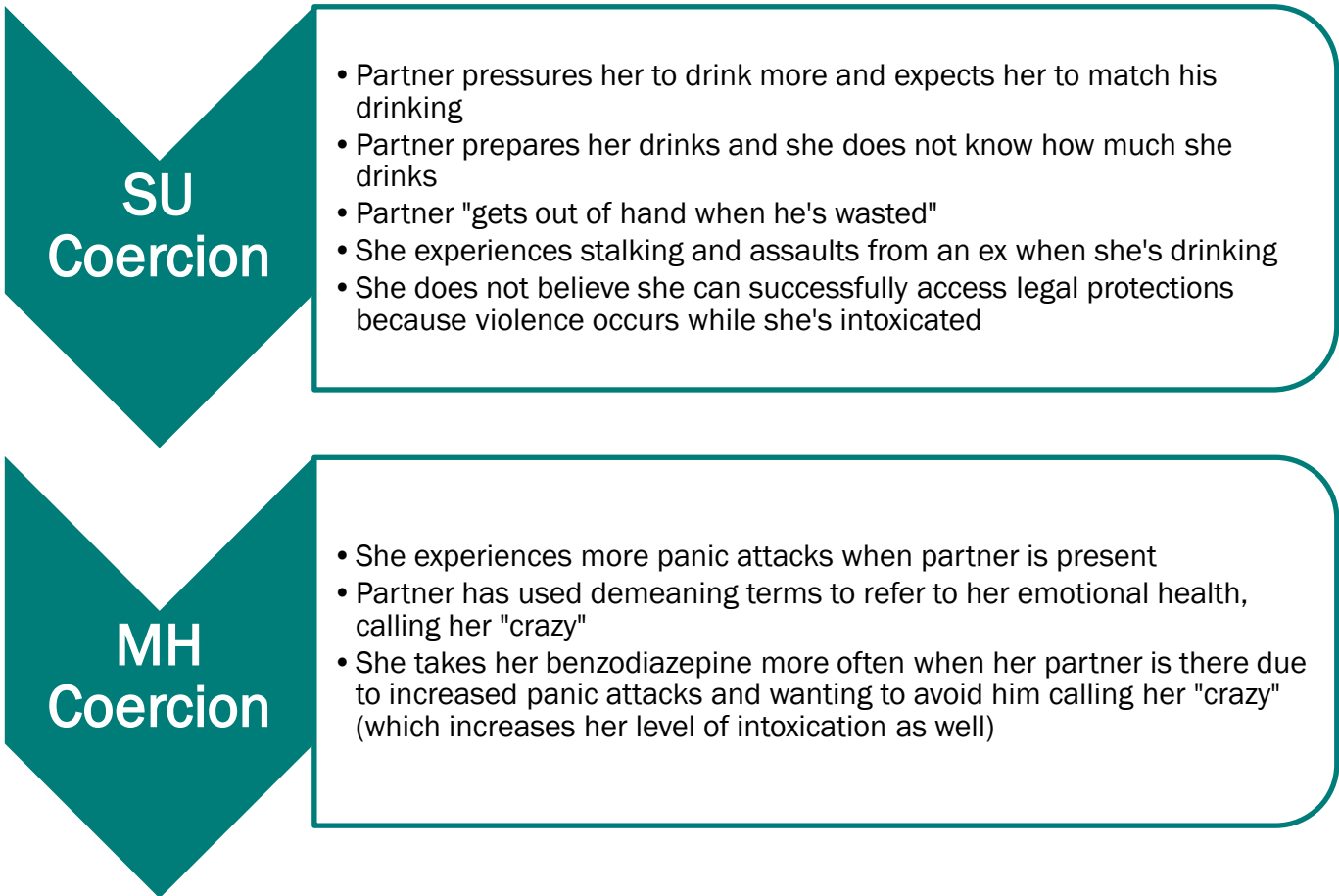
- History of DV, SA
- Does not eat a regular meal every day
- Experiences panic attacks, moreso when her partner is present
- Seeks relief from nervousness and relaxation when using alcohol; seeks to prevent or stop panic symptoms when using prescribed benzodiazepine

## Setting

- Lives alone with her dog in a rural area
- Sometimes drives while under the influence of alcohol
- Socially isolated (both relationally and geographically)
- Actively being stalked and attacked by ex-partner
- Current partner stays over 2-3 days/week, drinks hard liquor, prepares their drinks, and encourages her to match how much he drinks
- Mmore likely to take prescribed benzodiazepine when partner is present

What stage in her process of change might Victoria be in related to her use of alcohol? Based on what's been shared, it seems like she may be in a *precontemplation* phase, where she's not currently considering changes related to her alcohol use.

Now let's add another dimension in considering Victoria's situation and reflect on some of the ways she is likely experiencing coercion related to substance use and mental health.



### Examples of SUM Strategies for Victoria

It is essential that strategies are freely selected by Victoria because she is the expert on what may increase her safety, especially in the context of substance use coercion. Strategies that may decrease potential risks related to substance use could, at the same time, increase the danger she faces from DV/SV and substance use coercion. Combined safety planning that takes into account the dangers she faces from DV/SV, substance use coercion, and substance use, is an essential aspect of supporting her overall safety and well-being.

Lists of potential strategies as well as areas for further consideration in safety planning have been included below in order to help generate ideas for potential ways to reduce risks/harms. In practice, our role is to partner with Victoria and offer support as she comes up with and weighs different options (if she welcomes this support from us). If Victoria declines this kind of support from us, then we focus on



continuing to build the kind of relational and program environment that shows us to be trustworthy and nonjudgmental, while still being present to support Victoria with whatever needs she identifies.

**Drug-Specific:** Given the amount and frequency of Victoria’s alcohol use, it may be life-threatening for her to suddenly stop drinking alcohol without medical withdrawal management support. We can support Victoria in making small adjustments to her alcohol use, while also providing information on the need for medical support if she wishes to completely stop. We can ask Victoria to let us know if she’s interested in completely stopping her alcohol use so that we can link her with the right support at that time. Overdose prevention support, including creating an overdose prevention safety plan, would be especially important given her combined alcohol use and prescribed benzodiazepine. These strategies in particular (below) require thoughtful conversation about whether they are safe or realistic for Victoria given the substance use coercion she experiences. Victoria is the only one who can determine if and when it would be safe for her to try any of these strategies.

- Reducing the amount of alcohol she consumes each day (for example, she may decide to cut back from 12 beers to 10 beers)
- Learning standard drink measurements so she can accurately track how much she is drinking
- Making her own drinks using standard drink measurements so that she can know how much she is drinking
- Making her own drinks and diluting them by adding more water or other “mixers” in order to navigate expectations that she drink more in order to “keep up” with her partner’s alcohol use
- Reducing the amount of time she spends drinking alcohol (for example, she may find it helpful to delay the start of her drinking until after noon)
- Avoiding mixing her benzodiazepine with alcohol
- Exploring alternative prescriptions (that may not be as risky to take with alcohol) and/or alternative remedies for panic attacks. If she is interested in exploring potential options, we would need to collaborate with her prescriber as well.

**Set-Specific:** This array of strategies will rely largely on our ability to earn Victoria’s trust and create a relational environment that can overcome the stigma and shame she may experience. These insights are essential not only to helping Victoria select safer strategies around her substance use, but also for effective safety planning. Below are suggested areas for conversation with Victoria in order to better understand her situation and help her identify what might be helpful.

- Exploring what she finds helpful/beneficial about drinking alcohol. Is it numbing feelings of physical and/or emotional pain? Does it reduce her sense of isolation? About how much alcohol does she think she needs to drink before reaching these desired benefits? At what point does she start to experience the negative aspects of alcohol use? What helps her stay within the window of maximizing her benefits while minimizing her risks?
- What is the relationship between alcohol use and panic attacks? What might be some strategies to help her find alternative ways of dealing with panic attacks?
- How is her experience of alcohol use different when she eats food? What is different on the days she eats versus the days she does not eat? What helps her eat? Is there a way to build in a ritual that involves increasing her food intake while she uses alcohol?
- What is going on for her on days that she is more likely to combine alcohol and the prescribed medication? What is her process for deciding if and when to take this medication? Does she make different choices about her alcohol use when she decides to take her medications? What strategies does she use to stay as safe as possible while taking medication and using alcohol?

**Setting-Specific:** These strategies will focus on increasing Victoria's safety in any environment where she may obtain, use, or recover from use of substances.

- Separate use from driving (this would likely involve making a plan of how she can use alternative means of transportation available in her community and/or take care of any responsibilities that require her to drive prior to beginning alcohol use that day)
- Remove all alcohol and prescribed medications from her car

Because setting-specific SUM strategies focus largely on the people, environments, and situations that surround substance use, here are a set of questions that could be helpful to explore with Victoria as part of combined safety planning.

- What is her dog walking routine and how does it interact with her drinking routine? What potential strategies could help increase her safety while walking her dog?
- Explore how she obtains alcohol, and how that impacts her alcohol use as well as her personal safety. Does she tend to purchase in bulk with the expectation that it will last several days, and if so, does she end up drinking more than she planned? Would it reduce her risk to purchase smaller amounts of alcohol, or would that increase her risk if it means that she will drive to

- purchase more once she's finished what she has? In particular when safety planning around substance use coercion: are there safety risks to consider if she runs out of alcohol and her partner wants to continue drinking?
- What is the relationship between her alcohol use and her intimate relationship? What are the ways that her alcohol use supports or reduces her sense of safety when her partner visits? Is she drinking more alcohol not only to “keep up” with him, but also as a way to soothe the increased emotional stress caused by him, and/or as a way to soothe him in hopes of avoiding abuse? Is she drinking more alcohol when he visits in hopes that he will also drink more and fall asleep prior to “getting out of hand”? Is she drinking more as a way to soothe herself because she anticipates him ‘getting out of hand’? This is an especially important area to explore and consider in ongoing safety planning, and a major reason why it is vital we remain rooted within a survivor’s self-defined strategies and support autonomy
  - What is the relationship between her pattern of use and her other social support(s)? What is her experience of alcohol use when she visits with her closest friend?
  - What are some safe ways to increase social activities and relationships that do not center the use of substances?

**Program Considerations:** Here are some things we will want to consider as a program and have in place to better support Victoria.

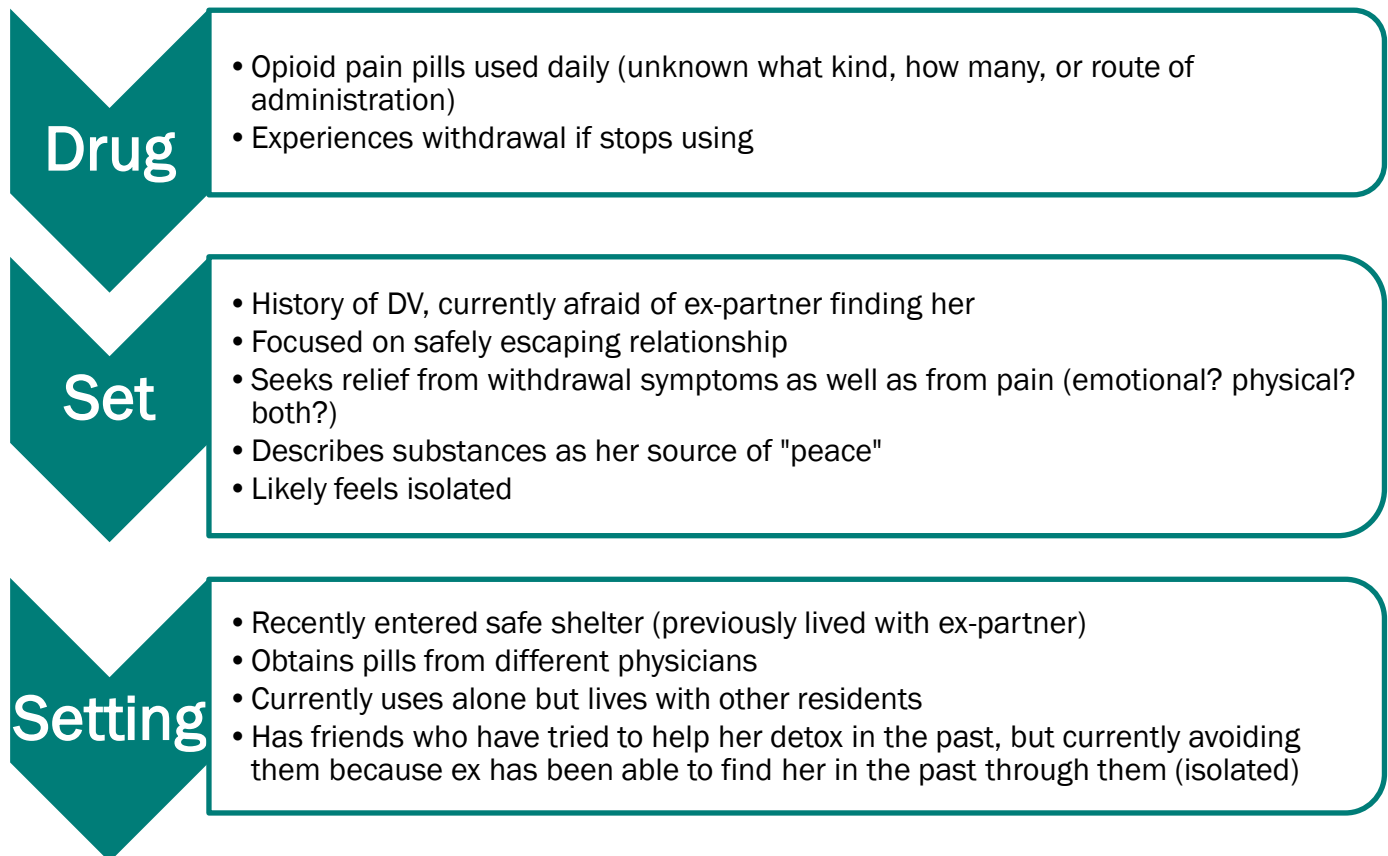
- How are we helping Victoria reduce potential feelings of guilt, shame, and/or self-blame? Through actively listening with empathy and responding with validating and normalizing statements, we can help Victoria to reduce any self-blame she may experience.
- What kinds of opportunities for healthy social engagement and community building can we offer through our programming?
- Are we considering and openly discussing what it might be like for Victoria to implement her DV safety plan while she is intoxicated? What adjustments need to be made in her plan to make it more realistic in the case that she is intoxicated? Does she need a slightly different plan if she is in a more intoxicated state?
- Are we able to meet her at her home so as to minimize the likelihood of her driving while intoxicated to an appointment with us? How can we strategize to meet her when her partner is not present? What kind of support do staff need to be able to provide home visits?

- What is our policy on someone driving to our services while potentially under the influence of substances? Does our policy need to be clarified/created? What is our process for making Victoria aware of our policy? How can we support Victoria in creating a realistic plan to avoid driving while under the influence, as well as what we can do to maintain her safety and the safety of the community if she drives herself to our program's services while under the influence? Having a collaboratively written plan in advance of this potential situation supports both staff and Victoria in knowing what to do/what will happen if this occurs.
- If Victoria wants to include her safe social support in her safety planning and other services, how can we collaborate with her safe social support in supporting Victoria?
- Have we included Victoria's dog in her safety plan? Have we talked about who might be able to take care of her dog temporarily if the need arises? Pet care is often a reason people feel they cannot access treatment, and may be easier to plan for if talked about more generally.
- Have we developed resources and relationships with treatment providers in case Victoria decides to stop using alcohol? What treatment providers are aware of DV-related needs, and are they accessible for Victoria? What can we do to support Victoria's access to effective treatment services, should she choose to engage this resource?
- How can we support Victoria's food access? Do we have food supplies that are easily accessible? Do we know what kind of foods Victoria finds comforting? Can we routinely build in desirable food as part of our meetings and services?

### Substance Use Management: Morgan

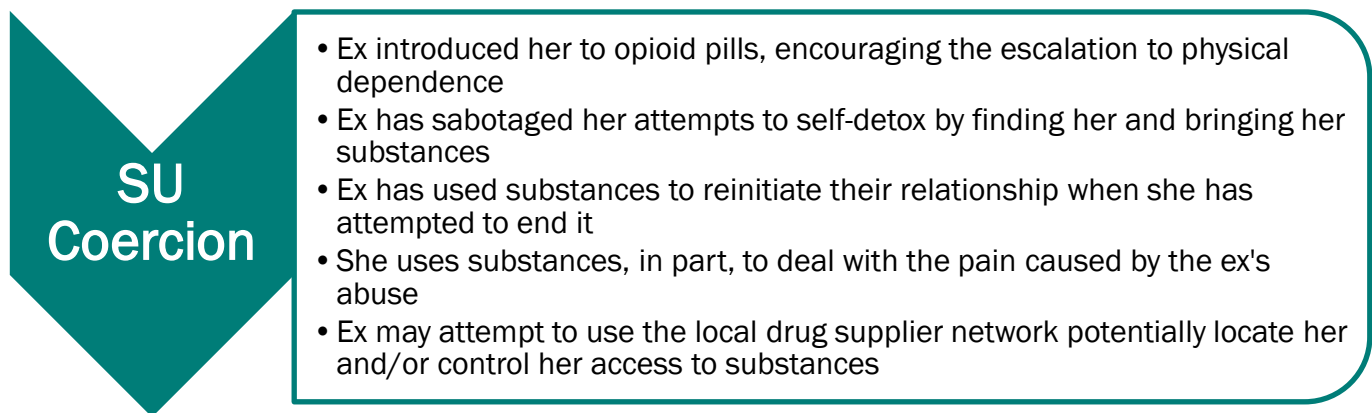
Morgan is a 23-year-old woman who recently entered safe shelter. She was introduced to opioid pills by her ex-partner, becoming physically dependent on them, and experiences withdrawal whenever she runs out of pills. She has been going to different doctors to get prescriptions and shares that she avoids buying pills off the street because she doesn't want her ex to find her. When she has tried to leave the relationship and self-detox in the past at friends' houses, her ex has found her and brought her more pills, at which point she then finds herself back in the relationship. She shares that the pills mainly help her avoid withdrawal at this point, but she also recognizes that on some level they are helping her deal with the pain of what she's going through. She describes the pills as her "only peace of mind." She states that she cannot contact her friends because she thinks her ex will be able to find her through her friends, and she cannot go back to this relationship. When asked about whether she's interested in treatment resources, she responds, "No... no, that is not where my head is at. I can't even think about that right now."

Let's first think about what we know about Morgan's situation using a Drug-Set-Setting perspective:



What stage of change might Morgan be in related to her seeking treatment for opioids? Based on what's been shared, it seems like she may be in a *precontemplation* phase, where it just feels like too much to consider attending treatment at this time. That said, Morgan may be open to considering other ways of improving her overall well-being in relation to her opioid use.

Now let's add another dimension in considering Morgan's situation and reflect on some of the ways she has likely experienced substance use coercion.



**SU  
Coercion**

- Ex introduced her to opioid pills, encouraging the escalation to physical dependence
- Ex has sabotaged her attempts to self-detox by finding her and bringing her substances
- Ex has used substances to reinitiate their relationship when she has attempted to end it
- She uses substances, in part, to deal with the pain caused by the ex's abuse
- Ex may attempt to use the local drug supplier network potentially locate her and/or control her access to substances

### Examples of SUM Strategies for Morgan

Again, it is essential that strategies are freely selected by Morgan because she is the expert on what may increase her safety, especially in the context of substance use coercion. Strategies that may decrease potential risks related to substance use could, at the same time, increase the danger she faces from DV and substance use coercion. Combined safety planning that takes into account the dangers she faces from DV, substance use coercion, and substance use, is an essential aspect of supporting her overall safety and well-being.

Lists of potential strategies as well as areas for further consideration in safety planning have been included below in order to help generate ideas for possible ways to reduce risks/harms. In practice, our role is to partner with Morgan and offer support as she comes up with and weighs different options (if she welcomes this support from us). If Morgan declines this kind of support from us, then we focus on continuing to build the kind of relational and program environment that shows us to be trustworthy and nonjudgmental, while still being present to support her with whatever needs she identifies.

**Drug-Specific:** Given what little we know about Morgan’s experience of opioid use and history of attempts to self-detox, it will be especially important for us to resist any attempts at persuading her to detox. Any attempts to persuade Morgan to detox from opioids is likely to replicate the ways that the ex-partner used opioids as a way to control her (substance use coercion). We will want to remain really focused on Morgan’s self-defined needs, and can just let her know that if at any point she feels interested or ready to talk about opioid treatment options in the future, we’re here to help. In the meantime, it will be important to provide overdose prevention support, including creating an overdose prevention safety plan and connecting with naloxone resources.

- Starting low and going slow when she uses opioids (so that she can check where her tolerance may be in that moment and potentially prevent overdose)
- Reducing the amount of opioids she consumes each day (and incorporating an understanding of how her tolerance will decrease when she reduces the amount used into overdose prevention planning)
- Avoiding mixing the opioid she uses with any other substances, especially any other ‘downers’ (such as other opioids, alcohol, or certain medications like anti-anxiety or sleep medications)
- Changing the route of administration to one that is less risky or direct (for example, to switch from injecting to snorting, or from snorting to swallowing)

**Set-Specific:** This array of strategies will rely largely on our ability to earn Morgan’s trust and create a relational environment that can overcome the stigma and shame she may experience. These insights are essential not only to helping Morgan select safer strategies around her substance use, but also for effective safety planning. Below are suggested areas for conversation with Morgan in order to better understand her situation and help her identify what might be helpful.

- Exploring what she finds helpful/beneficial about using opioids. Is it numbing feelings of physical and/or emotional pain? Does it reduce her sense of isolation? About how much does she think she needs to use before reaching these desired benefits? At what point does she start to experience the negative aspects of opioid use? What helps her stay within the window of maximizing her benefits while minimizing her risks?
- What are some alternative strategies to meet these needs? How can we help her to rebuild her sense of safety?

- Are there any health (physical and/or mental) needs that she identifies? How can we support her overall wellness?

**Setting-Specific:** These strategies will focus on increasing Morgan's safety in any environment where she may obtain, use, or recover from use of substances. Because setting-specific SUM strategies focus largely on the people, environments, and situations that surround substance use, here are a set of questions that could be helpful to explore with Morgan as part of combined safety planning.

- Explore how she obtains opioid pills and how that may impact her personal safety. How can we help her to safety plan around this?
- When and where does Morgan tend to use? Is she in a safe place? Does her intoxication level vary throughout the day, and if so, how does that interact with her safety?
- Do people around her know how to recognize and respond to overdose?

**Program Considerations:** Here are some things we will want to consider as a program and have in place to better support Morgan.

- How are demonstrating our nonjudgmental stance and meeting Morgan where she is? Are we approaching Morgan's use in a matter-of-fact manner? How are we using empathy and validation to come alongside Morgan as an ally?
- Does Morgan have a lockbox to be able to securely store her medications?
- Are staff trained in how to recognize and respond to a potential opioid overdose? Do staff have access to naloxone if a resident is potentially overdosing? Is this education offered to Morgan and other residents who are interested in learning how to recognize and respond to overdose?
- What kinds of opportunities for healthy social engagement and community building can we offer through our programming? How are we engaging and including Morgan in creating connections with other residents and with staff?
- Are we considering and openly discussing what it might be like for Morgan to implement her DV safety plan if she is feeling very drowsy? What adjustments need to be made in her plan to make it more realistic in the case she is intoxicated? Does she need a slightly different plan if she is in a more intoxicated state?



- If Morgan wants to include a safe social support in her safety planning and other services, how can we help Morgan determine who may be safe supports? How can we support Morgan in increasing her safety if she decides to visit with friends?
- Do we have information on treatment for opioids and treatment resources available for Morgan to be able to read/consult without necessarily having to ask for it? It could be a treatment locator phone number and website posted on a bulletin board, as well as brochures on opioid treatment along with other informational materials.
- Have we developed resources and relationships with treatment providers in case Morgan decides she is interested in and ready for treatment? What treatment providers are aware of DV-related needs, and are they accessible? What can we do to support Morgan's access to effective treatment services, should she choose to engage this resource? Are there Medication-Assisted Treatment providers in the area? Do any treatment providers use telemedicine, and if so, do we have the technology and confidential space for Morgan to access services from safe shelter via telemedicine?
- Do we have accessible information on harm reduction resources, including naloxone distribution and peer-based support? Have we developed relationships with local harm reduction organizations in case Morgan is interested in this connection?
- What kinds of support groups and activities do we offer on-site for people with substance use histories?
- How do we offer support and resources to other residents who identify as being in recovery and may feel cravings to use? How do our responses counteract stigma and shame if other residents react negatively towards Morgan due to assumptions made about her substance use?

In both Victoria's and Morgan's situations, we can see how being able to unpack the dynamics of their substance use experience prepares us to understand the intricacies of their experience as well as help them generate options and strategies that support safety and well-being.

## Overdose Prevention

Accidental overdose fatalities are at an all-time high and continue to increase at alarming rates. According to the Center for Disease Control and Prevention's National Center for Health Statistics, more people have died from accidental overdose than from car crashes, gun violence, or AIDS during the peak of the AIDS epidemic. It is the leading cause of death for people under age 50. In 2017 alone, over 72,000 people died from an accidental overdose, leaving behind countless grieving loved ones. In one way or another, each of us has been tragically touched by this overdose epidemic.

Programs play a crucial role in preventing and reversing overdoses. We can help save lives by:

- Building safety into our conversations and settings for conversations about substance use to emerge.
- Encouraging open conversations that center the survivor's perspective.
- Learning risk factors for overdose.
- Learning to recognize overdose and how to reverse overdose due to opioids.
- Having naloxone on hand in case of an opioid overdose.
- Helping survivors develop strategies to decrease risk of overdose.
- Sharing overdose prevention information with survivors, and when appropriate and with a survivor's consent, their social supports.
- Share unbiased information in a nonjudgmental and noncoercive manner.
- Helping survivors create an overdose prevention plan.
- Integrating knowledge of substance use and substance use coercion into safety planning.
- Connecting survivors (and their social supports, when appropriate) with naloxone kits.
- Facilitating access to medication assisted treatment.

Many states have enacted Good Samaritan laws that offer varying levels of protections against being arrested, charged, and/or prosecuted for possession of substances and/or paraphernalia when individuals are seeking emergency medical care for an overdose. Find out what kind of Good Samaritan laws exist in your state, share this information with survivors, and advocate for more comprehensive

Good Samaritan laws (where appropriate). The last thing we need in this overdose epidemic is people dying because of fear of legal issues.

### What is an Overdose?

An overdose is a *relatively* large dose that has exceeded a person's tolerance for a substance, resulting in serious negative impacts on their physical health, mental health, or both. It is important to note that the amount of substance that is considered "large" is relative to a person's tolerance at that given moment, so very small amount of a substance could produce an overdose if that person's tolerance is particularly low at that point (and/or the substance is particularly strong).

### Overdose Risk Factors

There are a number of risk factors that can increase a person's risk of fatal overdose. Knowing these risk factors and sharing this knowledge can help survivors make more informed choices and develop strategies to reduce their risks.

- Using alone: there is no one to recognize the overdose, reverse it, and get help.
- A history of past overdoses: previous overdoses lower one's overdose threshold, making it easier to overdose in the future.
- Not having an overdose prevention plan: lack of support and planning for how to prevent an overdose, including access to naloxone, increases a person's risk for death if they do experience an overdose.
- Physical health conditions: it is easier to overdose when our internal systems and/or organs are already compromised by a health condition.
- Using more than one substance at a time, including alcohol and/or prescriptions.
  - Using opioids with other "downers" (such as alcohol, sleep aids, anxiety medications, or mixing different kinds of opioids) will create stronger effects that depress breathing, making overdose more likely. People may not realize the substance they are using is mixed with others.
  - Using opioids or depressants and stimulants together may result in someone using larger quantities or for a longer period of time because the unwanted effects of one drug is

masked by another. Also, stimulants will generally wear off faster, potentially leaving someone at increased risk of opioid overdose.

- Not “testing” the dose: by using a tiny amount of the substance to “test” it (rather than going directly to using their more typical amount) the person can better understand both the strength of the substance as well as their current tolerance level.
- Recent period of abstinence: tolerance, especially to opioids, can change quickly and dramatically, even within the same day. A recent period of abstinence reduces a person’s tolerance level, making overdose more likely. Recent abstinence may not be planned or voluntary, but could be due to recently being in a setting where substance use is not allowed or available, such as a shelter, jail, a nursing home, or after hospitalization.
- Erratic pattern of use: inconsistent use, or using different forms of substances (or perhaps the same substance but from different sources) can all lead to dramatic shifts in tolerance.
- History of depression, low mood, impulsivity, suicidality, and/or self-injury: someone with this history may be less likely to take measures to prevent overdose, and/or may use in a more haphazard or impulsive manner.
- Detoxification from opioids without maintenance medication: reduces a person’s tolerance as well as increases the risk of return to use, creating a very high risk for overdose.
- Faster route of administration: routes of administration that are more direct increase the risk of overdose because a larger and stronger amount of the substance is more quickly absorbed by the body. Using intravenously presents the highest overdose risk, followed by snorting, then smoking, then eating the substance. That said, it is possible to overdose by any route of administration.
- Seeking profound intoxication: someone who seeks the sensation of profound intoxication is more likely to use a larger amount and/or a more direct route of administration.

## Overdose Prevention

Helping survivors prevent and reverse overdoses requires us to both have this foundational knowledge, as well as build radically strong and trusting relationships with survivors that can counteract the effects of stigma. Here are some key strategies in helping survivors to prevent fatal overdose:

- Collaboratively create an overdose prevention plan.
  - The best prevention plan is one that is realistic and actionable for the individual, which might not be the same as what we think is an “ideal” plan. Much like DV safety planning, overdose prevention planning is only as useful as it is individualized. One way to open this conversation is by asking, “What are some things you do to stay as safe as possible while using substances, including alcohol?”
  - This plan will likely need to be integrated into ongoing DV safety planning due to the pervasiveness of substance use coercion.
- Help create access to naloxone.
  - Partner with your local harm reduction and/or public health agencies, who may distribute naloxone or know how to obtain it within your community.
  - Some states have naloxone available at local pharmacies, and it can be covered by insurance in many cases. Be sure to call ahead to see where it is available, and whether there will be any financial cost associated with obtaining it.
- Help individuals understand how tolerance can shift frequently and dramatically, especially with changes in their environment, as well as the frequency or amount of substances used.

### Potential Risk Reduction Strategies

- Start with a small amount and use slowly, especially when their pattern of use has recently changed, or is erratic.
- Avoid mixing substances, especially “downers.”
- Testing street-based substances for fentanyl.
- Use when others who could recognize an overdose and call for help are around.
- Keep a naloxone kit nearby when using.

### **What Goes in a Naloxone Kit?**

**Required:** three doses of naloxone (if using injectable naloxone, also need three intramuscular syringes) and an instruction card for overdose reversal. **Optional:** breathing mask, rubber gloves, alcohol pads.

## Overdose Reversal

There is a growing presence of **opioids** (specifically fentanyl) in non-prescription **stimulants** (cocaine, amphetamines, and methamphetamines). While naloxone (the overdose antidote) only works to reverse an opioid overdose, keep in mind that opioids might be found in stimulants as well. If you see signs of an opioid overdose, follow the protocol for reversing an opioid overdose, as there may be an opioid mixed into the substance they used.

### Recognizing an Opioid Overdose

It can take *hours* or *seconds* for a person to overdose. A common question is how to tell the difference between someone who is profoundly intoxicated and someone who is experiencing a life-threatening overdose. The main difference will be that the person who is profoundly intoxicated can be woken up and respond, whereas the person who is overdosing will be minimally responsive.

Profound Intoxication	Overdose
Pupils (black center of eyes) become very small (same as overdose)	Pupils (black center of eyes) become very small (same as intoxication)
Can be woken up (responds to having their name called, a light shake, sternal rub, etc.)	Unresponsive, or may be able to open eyes but not speak
Speech is slurred	Speech is severely restricted (either cannot speak, or can only speak very repetitive/simple words)
Breathing regularly (8 or more times/minute)	Breathing is slow (less than 8 times/minute) or has stopped. Breathing may be labored, and sound like choking, snoring or gurgling.
Color of lips and fingertips looks normal	Lips and/or fingertips may appear blue or gray (depending on skin tone)

## Reversing an Opioid Overdose

With training and support, just about anyone can reverse an opioid overdose and save a life. If you notice signs of a potential overdose, here's what to do:

1. Stimulate: call their name, lightly shake them, attempt to wake them by rubbing using your knuckles on their sternum (upper middle of chest where one's ribs meet) and/or upper lip.
  - a. If they respond, see if they can speak and are breathing normally.
  - b. If their speech is severely limited, or their breath is shallow, or the person says they are having trouble breathing or chest pains, call 911.
2. Call 911: while we can do a lot to help save someone's life, naloxone (the overdose antidote) only *temporarily* reverses an overdose. Emergency medical attention is needed. If possible, ask another staff member to call 911 or call 911 using a hands-free method (such as speakerphone) so you can continue to help the person while calling.
  - a. What to say when calling 911: be sure to describe whatever overdose signs are present, such as slow/stopped breathing, unresponsiveness, etc., and give your exact location.
3. Administer naloxone: naloxone comes in three main forms - nasal spray, injectable, and auto-injector. It is best practice to know how to administer all forms of naloxone so you can administer it during a crisis, as well as teach someone else how to use whatever form of naloxone they may be able to access. Please see the appendix for instructional resources.
4. Rescue breaths: check the person's airway (ensure there's nothing in their mouth or blocking their throat), if there's anything in their mouth/airway use a hooked finger sweep to remove it, tilt their head back, open their mouth, pinch their nose, and give breaths every five seconds.
5. Evaluate: after 2-3 minutes, check to see if the person has become responsive and started breathing normally. If not, administer another dose of naloxone. Overdoses that involve fentanyl (a particularly strong opioid) often require multiple doses of naloxone.
6. Post-overdose support: once the naloxone has been effective in reversing the overdose, continue to support the person until first responders arrive. Provide emotional support, explain what has happened, and prevent them from using more (if they try to do so). Naloxone only *temporarily* reverses an overdose, and the person can return to overdosing once it wears off. Hopefully by now, first responders have arrived and are providing urgent care. If you need to leave the person

at any time (for example, to open the door for first responders), leave the person in the *recovery position* to prevent them from choking.



The **recovery position** involves laying the person on the ground turned on their side (the top leg can be bent with the knee placed on the ground to prevent rolling onto stomach).

Recognizing and Responding to a Stimulant Overdose (such as Methamphetamine or Cocaine)

Severe signs of an overdose due to stimulants includes: difficulty breathing, high blood pressure, high body temperature, extreme agitation/anxiety, hallucinations, chest pains, irregular heart rhythm, seizures, and stroke. Call for emergency medical care while keeping the person as calm and comfortable as possible. Naloxone only works on opioids, and there is no similar medication at this time to reverse a stimulant overdose outside of an emergency medical setting.

What NOT to Do During an Overdose

There are many myths surrounding overdose, here’s is a list of what NOT to do, and why:

What NOT to Do	Reason
Do not put the person in a bath.	They could drown.
Do not put ice on them.	They could go into shock.
Do not induce vomiting or give them something to eat or drink.	They could choke.
Other than naloxone, do not give medications, over-the-counter drugs, street drugs, caffeine, or vitamins.	They don’t help.
Do not try to walk the person around in hopes of waking them up.	This doesn’t work, wastes time, and could lead to tripping and falling.
Do not leave the person to “sleep it off.”	What may seem like sleeping or snoring may actually be a person overdosing.
Do not run away – call 911!	Overdose situations can feel frightening, but we need to face our fears and try to save a life.



## After an Overdose

A trauma-informed approach includes follow-up support after an overdose event.

- Supporting the person who overdosed: People may experience a range of complex emotions after surviving an overdose, including fear and humiliation; and are at increased risk for overdosing again in the future. Offering empathetic emotional support as well as matter-of-fact overdose prevention planning can help a person to restore their sense of safety and well-being.
- Supporting staff: provide emotional support directly after the event as well as in the days (or weeks) following, depending on staff needs/preferences. It is common for people to react differently and individualized forms of support are key.
- Supporting others in the program who witnessed or were impacted by the situation: sometimes others in the program are directly involved in the overdose situation as neighbors or bystanders, or may be personally impacted as a friend or acquaintance. Overdose situations can be scary and potentially tragic. Just as with staff and teammates, we want to offer support to other survivors in the program who may have been impacted. This can include individualized emotional support as well as group-based support.
- Support in the case of a tragic loss: One of the harsh realities of this overdose crisis is that we can do everything in our power to try to prevent fatal overdose, and still, we may lose people to overdose. If this happens, it's important to offer grief support and opportunities for honoring the person who has passed. Supervisors can also be supportive by taking care of any required paperwork and reporting on behalf of staff. August 31st is International Overdose Awareness Day; you can find free resources to plan awareness and remembrance activities here: [www.overdoseday.com](http://www.overdoseday.com).

The knowledge of how to prevent, recognize, and respond to a potential overdose is empowering and life-saving. For additional training, materials, and resources, check out:

- NCDVTMH's webinar: Overdose Prevention and Reversal in Anti-Domestic Violence Advocacy: <https://ncdvtmh.webex.com/ncdvtmh/onstage/playback.php?RCID=2a5adad1a1263286d4a5e1b345d91808>
- Detailed naloxone instructions can be found in the appendix
- Local harm reduction organizations, recovery community organizations, and public health offices

NCDVTMH is here to support programs seeking to increase their capacity and confidence in overdose prevention and reversal efforts.

## Conclusion

Substance use has been a part of the human experience since the beginning of recorded history. There never has been a truly substance-free society and yet, stigma continues to characterize many of our approaches to people who use substances. This very stigma is often used by abusers to keep their intimate partner under their control. As long as substances permeate the human experience, substance use and substance use coercion will continue to impact the lives of people experiencing abuse. This means that supporting a survivor with their substance use concerns falls within our purview because everyone has a right to safety. Otherwise, survivors who use substances get caught between siloed systems with no real access or help from anyone.

Working to expand an ACRTI approach to support survivors who use substances requires building relationships with survivors that are based on empathy, collaboration, and most importantly, support the individual's personal choices, values, perspective, and preferences. In this way, we break free of the expectation that abstinence is the only goal within recovery. It takes time to reclaim one's sense of self beyond the effects of domestic violence, trauma, and stigma. Individuals can begin to untangle these complex dynamics and realize their personal path towards healing when their emotional and physical safety is supported within DV programs. Organizations can have the greatest impact in promoting safety for survivors, their children, and staff, when policies and practices make it safe for survivors to talk about their substance use experiences.

## Resources and References

- American Society of Addiction Medicine. (2017). Consensus Statement on Appropriate Use of Drug Testing in Clinical Addiction Medicine. Retrieve from: <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>
- Balousek, S., Plane, M.B. & Fleming, M. J GEN INTERN MED (2007) 22: 1268.  
<https://doi.org/10.1007/s11606-007-0257-6>
- BC Society of Transition Houses. (2011). Report on Violence Against Women, Mental Health and Substance Use. Retrieve from: [https://www.canadianwomen.org/wp-content/uploads/2018/03/PDF-VP-Resources-BCSTH-CWF-Report\\_Final\\_2011\\_-Mental-Health\\_Substance-use.pdf](https://www.canadianwomen.org/wp-content/uploads/2018/03/PDF-VP-Resources-BCSTH-CWF-Report_Final_2011_-Mental-Health_Substance-use.pdf)
- BC Society of Transition Houses. (2011). Reducing Barriers to Support for Women Fleeing Violence: A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use. Retrieve from: <https://bcsth.ca/publications/reducing-barriers-to-support-for-women-fleeing-violence/>
- Beaudoin, F. L., Banerjee, G. N., & Mello, M. J. (2016). State-level and system-level opioid prescribing policies: The impact on provider practices and overdose deaths, a systematic review. *J Opioid Manag*, 12(2).
- Bernardy, N., Montañó, M. (2019). Opioid Use Among Individuals with Posttraumatic Stress Disorder. *PTSD Research Quarterly*, 30(1).
- Bigg, D. (2001). Substance Use Management: A harm reduction-principled approach to assisting the relief of drug related problems. *Journal of Psychoactive Substances*, 33, 33-38. DOI: 10.1080/02791072.2001.10400466 Retrieve from: <http://www.anypositivechange.org/SUM.pdf>
- Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved 6/17/19 from <http://wonder.cdc.gov/ucd-icd10.html>

- Denning, P. & Little, J. (2012). *Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions*, 2nd ed. NY: The Guilford Press.
- Denning, P., Little, J. & Glickman, A. (2004). *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol*. NY: The Guilford Press.
- Facing Addiction with NCADD. (2018). Multiple pathways of recovery. Retrieve from: <https://www.facingaddiction.org/multiple-pathways-recovery>
- Global Commission on Drug Policy. (2012). The War on Drugs and HIV/AIDS: How the criminalization of drug use fuels the global pandemic. Retrieve from: [http://globalcommissionondrugs.org/wp-content/themes/gcdp\\_v1/pdf/GCDP\\_HIV-AIDS\\_2012\\_REFERENCE.pdf](http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf)
- Greaves, L., Chabot, C., Jategaonkar, N., Poole, N., & McCullough, L. (2006). Substance Use Among Women in Shelters for Abused Women and Children: Programming Opportunities. *Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique*, 97(5), 388-392. Retrieve from: <http://www.jstor.org/stable/41995746>
- Hari, J. (2015). Everything you think you know about addiction is wrong. Retrieved 8/22/16 from [https://www.ted.com/talks/johann\\_hari\\_everything\\_you\\_think\\_you\\_know\\_about\\_addiction\\_is\\_wrong](https://www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong)
- Harm Reduction Coalition (2011). *Getting Off Right: A Safety Manual for Injection Drug Users*. Retrieve from: [http://issuu.com/harmreduction/docs/getting\\_off\\_right/11?e=0](http://issuu.com/harmreduction/docs/getting_off_right/11?e=0)
- Hart, CL. (2015). Let's quit abusing drug users. Retrieved 8/20/16 from <https://youtu.be/C9HMifCoSko>
- Harvey, S., Mandair, S. & Holly, J (2013). *Case by Case: Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems*. London: AVA & Solace Women's Aid. Retrieve from: <https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Case-by-Case-London-refuge-provision-Full-Report.pdf>
- Hill, A. (2011). *Applying Harm Reduction Services for Substance Using Women in Violent Relationships*. Harm Reduction Communication, by the Harm Reduction Coalition. Retrieve from: <https://harmreduction.org/wp-content/uploads/2011/12/Communication6.pdf>
- Komaya, E. (2001). *Toward a Harm Reduction Approach in Survivor Advocacy*. Survivor Project, Spring newsletter. Retrieved from: <http://eminism.org/readings/harmreduction.html>

- McMillen, S. (2013). Rat Park. Retrieve from: [http://www.stuartmcmillen.com/comics\\_en/rat-park/](http://www.stuartmcmillen.com/comics_en/rat-park/)
- National Institute of Drug Abuse (NIDA, 2018). Medications to Treat Opioid Use Disorder. Retrieve from: <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview>
- New York State Dept. of Health AIDS Institute (2016). Policies and Procedures Syringe Exchange Programs. Retrieve from: [https://www.health.ny.gov/diseases/aids/consumers/prevention/needles\\_syringes/syringe\\_exchange/docs/policies\\_and\\_procedures.pdf](https://www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/syringe_exchange/docs/policies_and_procedures.pdf)
- Pennsylvania Drug & Alcohol Coalition (PDAC). (2010). Recovery-Oriented System of Care: A recovery community perspective. Retrieve from: <http://www.williamwhitepapers.com/pr/ROSC%20A%20Recovery%20Community%20Perspective%202010.pdf>
- Phillips, H., Lyon, E., Kaewken, O. (2019). Meeting the needs of domestic violence survivors who use substances: Initial findings. Chicago, IL. National Center on Domestic Violence, Trauma, and Mental Health.
- Prochaska, J., DiClemente, C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 1983(6).
- Stella Project. (2007). Stella Project Toolkit: Domestic Abuse and Substance Use. Retrieve from: <https://avaproject.org.uk/resources/stella-project-toolkit-domestic-abuse-substance-use-2007/>
- Stumbo, S. P., Yarborough, B. J., McCarty, D., Weisner, C., & Green, C. A. (2017). Patient-reported pathways to opioid use disorders and pain-related barriers to treatment engagement. *Journal of substance abuse treatment*, 73, 47–54. doi:10.1016/j.jsat.2016.11.003
- Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieve from: <https://www.samhsa.gov/data/>

- Van der Kolk, B. A., MacFarlane, A. C., & Weisæth, L. (Eds.) (2012). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York, NY: Guilford Press.
- Wakeman, SE & Rich, JD. (2018). Barriers to Medications for Addiction Treatment: How Stigma Kills. *Substance Use & Misuse*, 53(2), 330-333.
- Warshaw, C., Lyon, E., Bland, P., Phillips, H., & Hooper, M. (2014). *Mental Health and Substance Use Coercion Surveys*. National Center on Domestic Violence, Trauma, and Mental Health. Retrieve from: [http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH\\_NDVH\\_MHSUCoercionSurveyReport\\_2014-2.pdf](http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf)
- Warshaw, C., & Tinnon, E. (2018). *Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit*. National Center on Domestic Violence, Trauma, and Mental Health. Retrieve from: <http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a-toolkit/>
- Warshaw, C., Tinnon, E., & Cave, C. (2018). *Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations*. National Center on Domestic Violence, Trauma, and Mental Health. Retrieve from: <http://www.nationalcenterdvtraumamh.org/publications-products/tools-for-transformation-becoming-accessible-culturally-responsive-and-trauma-informed-organizations-an-organizational-reflection-toolkit/>
- Wheeler, E., Burk, K., McQuie, H., & Stancliff, S. (2012). *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*. Harm Reduction Coalition. Retrieve from: <https://issuu.com/harmreduction/docs/od-manual-final-links>
- White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27. Retrieve from: <http://www.williamwhitepapers.com/pr/2008RecoveryCapitalPrimer.pdf>
- Zinberg, NE. (1984). *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use*. Yale University Press.

## Appendices

- A. NCDVTMH's Integrated Approach: *Creating Trauma-Informed Services and Organizations*
- B. Glossary of Terms
- C. Myths and Misconceptions
- D. Naloxone Instructions
- E. Safer Bathrooms
- F. Mutual Aid Resources
- G. Information on Commonly Used Substances

## Appendix A: Creating Trauma-Informed Services and Organizations: An Integrated Approach<sup>4</sup>

### Introduction

The National Center on Domestic Violence, Trauma, and Mental Health's (NCDVTMH) approach to creating accessible, culturally responsive, and trauma-informed domestic and sexual violence services and organizations draws from a number of different places and perspectives - from the voices and experiences of survivors, advocates, and clinicians; from the insights of social and political movements; and from research and science, including a growing body of research on child development and neurobiology.

Initially developed as a way to bridge trauma-informed and advocacy perspectives, this more integrated approach has evolved into a framework for holding many of the key elements that are critical to doing our work - work that is grounded in domestic and sexual violence advocacy perspectives, that incorporates an understanding of trauma and its effects, that creates accessible environments for healing, that recognizes the centrality of culture, and that is committed to social justice and human rights.

More specifically, this framework provides a foundation for doing work that is inclusive and accessible, attuned to the range of people's experiences, and relevant to the people and communities we serve. It also provides a foundation for working in ways that are grounded in dignity, respect, and justice; that honor people's strengths and creativity; that foster resilience and healing; that attend to the well-being of staff, organizations, and communities; and that support activism and social change.

It provides additional scaffolding for holding the depth, nuance, sensitivity, attunement, self-awareness, and accountability that is so important to our interactions with others and the broader political awareness needed to understand our own and others' experiences in context. It also provides the inspiration, analysis, and tools to advocate for change within our organizations, in the systems that impact the lives of survivors, and in the attitudes and policies that contribute to abuse and violence in our world and restrict people's options. Given this, we use the term "survivor" to mean adults, adults

---

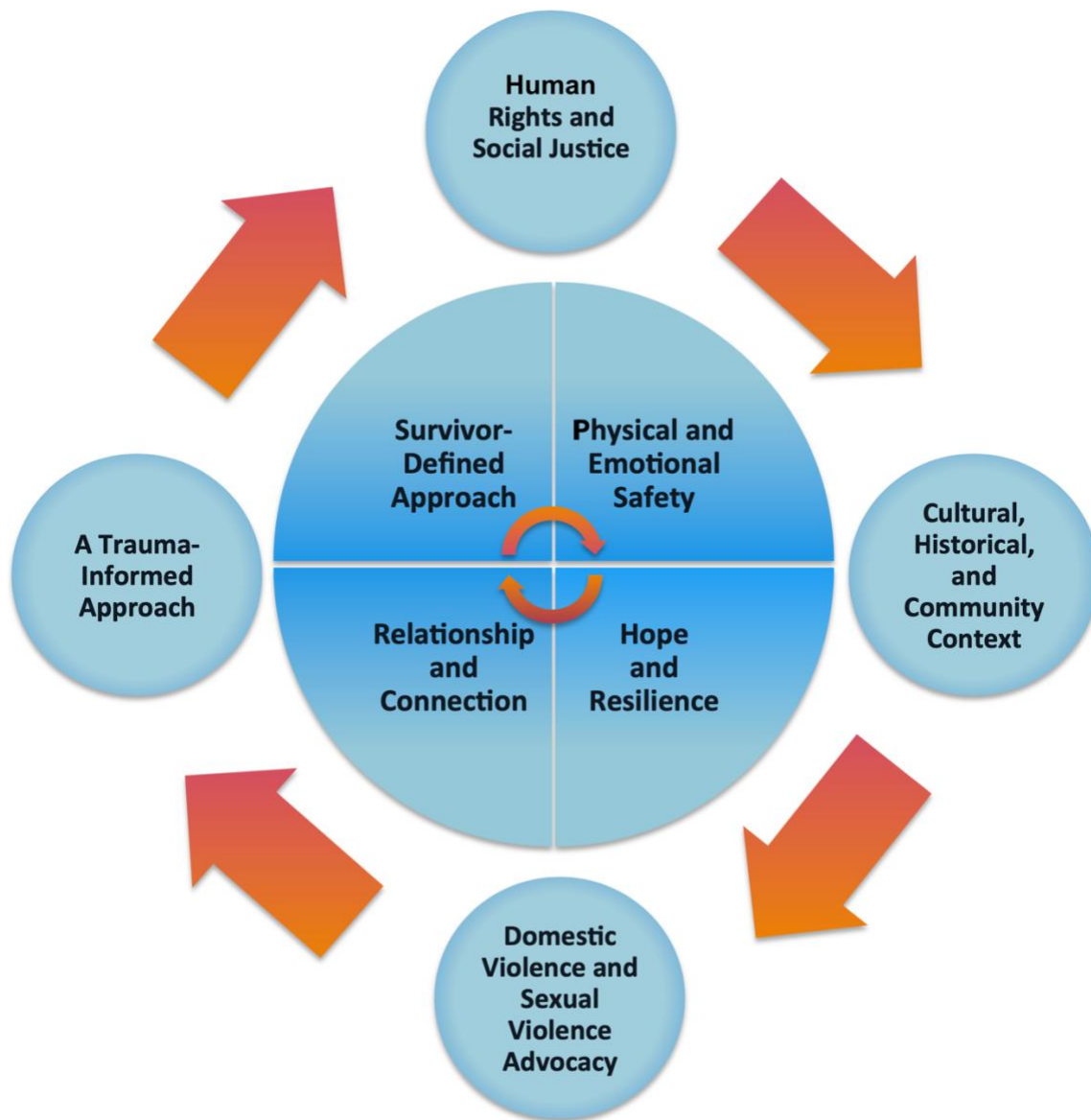
<sup>4</sup> Warshaw, C., Tinnon, E., & Cave, C. (2018). *Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations*. National Center on Domestic Violence, Trauma, and Mental Health.



and their children, youth, young adults, elders, and anyone in the family system – as defined by survivors – who have experienced or witnessed violence.

The following perspectives and principles help provide a foundation for accessible, culturally responsive, and trauma-informed work. They also offer a framework to draw on when our work becomes challenging and to support us in creating services and organizations that truly reflect our intentions and values. We hope that you can take strategies from this document to help you live and practice these values in your work.

**Key Perspectives and Core Principles for Engaging in Accessible, Culturally Responsive, and Trauma-Informed Work**



## Key Perspectives

NCDVTMH's framework is informed by several key perspectives, which, when woven together, provide a more integrated approach for working with survivors and their children. Each perspective offers an important dimension that helps inform how we conceptualize and how we do our work. All contribute to our ability to ensure our programs are welcoming, inclusive, and accessible.

### Domestic Violence and Sexual Violence Advocacy

This perspective highlights the importance of attending to not only the traumatic effects of domestic and sexual violence but also the ongoing realities of coercion and control by an abusive partner, and by the systems where survivors seek help. A domestic and sexual violence perspective also brings an analysis of gender-based violence, including transphobic, biphobic, and homophobic violence, to our work and emphasizes the importance of holding individuals and systems accountable for their abuse of power.

### Cultural, Historical, and Community Context

This perspective focuses our attention on the historical and social context of people's lives including their ongoing experiences of oppression, discrimination, and microaggression. It helps us recognize the richness and complexity of people's identities, beliefs, and experiences, and the traditions, values, and relationships that serve as sources of meaning and strength. It also places the creation of services that are inclusive, culturally responsive, and linguistically accessible at the forefront of our work.

### Human Rights and Social Justice

Incorporating human rights and social justice perspectives ensures that awareness of the conditions that create and uphold abuse, violence, oppression, and discrimination in our lives, our communities, and our society remains central to all that we do. It strengthens our ability to recognize social injustice, to critically analyze the conditions that produce it, and to work toward social change. It also helps us to be more attuned to any stigma or discrimination experienced by survivors and staff in our own programs and to actively take this on.

## A Trauma-Informed Approach

A trauma-informed perspective brings an understanding of the pervasiveness of trauma and its impact on survivors, our organizations, our communities, and ourselves, and what we can do to help mitigate those effects. It normalizes human responses to trauma and reminds us that the quality of our interactions is critical to the process of healing from abuse and trauma. A trauma-informed approach provides guidance on how trauma can affect people's experience of services and what we can do to reduce further traumatization at every level of our organizations. When we understand trauma responses as adaptations to being under siege, then part of our work is to do everything we can to reduce the likelihood that survivors will feel discounted and disempowered in our programs and systems. A trauma-informed perspective also informs the creation of services and environments that support the resilience and well-being of people and communities through the work we do and the way we work. A trauma-informed perspective acknowledges the need to support staff and to create opportunities for reflection and growth.

## Core Principles

The following core principles or values provide a foundation for doing accessible, culturally responsive, and trauma-informed work. They are all part of creating a relational environment that can help to counteract people's experiences of trauma and dehumanization - one that is deeply respectful and that honors and supports each person's experience, resilience, agency, and humanity. Central to this integrated approach is recognizing the importance of the quality of our interactions and the relationships we create. Each of the following principles represents a somewhat different aspect of this overarching approach. These principles include recognizing and honoring the importance of:

### Physical and Emotional Safety

A key aspect of accessible, culturally responsive, and trauma-informed work involves attending to both physical and emotional safety, with particular attention to culture and accessibility, while honoring each person's understanding of what safety means for them, and a commitment to ongoing self-reflection and evaluation of whether systems, policies, and procedures are facilitating feelings of safety among participants and staff.

## Relationship and Connection

Relationships are central to healing, growth, and change, including our relationships to the people, places, practices, and things that help us to cope, grow, and thrive. As harm often occurs in relationship, the quality of our relationships and interactions has the potential to facilitate healing from experiences of abuse and discrimination, and create a sense of connection and belonging. When trust has been betrayed, being honest, clear, transparent, and consistent and relating in ways that are genuinely respectful, collaborative, and non-hierarchical are essential to creating safety and building trust.

## Hope and Resilience

Believing in the human capacity to survive and heal, and recognizing the strengths, resources, and tools that survivors already possess, are central to holding hope and resilience. Being a steady source of hope, and acknowledging, naming, and reflecting people's profound resilience are critical parts of supporting survivors while they heal from trauma. It also means that we embody a genuine sense of openness in our relationships and our work.

## A Survivor-Defined Approach

Recognizing and honoring each person's right to define and determine what works for them, and guaranteeing choice and control over their experiences are critical components of a survivor-defined approach. This means taking cues and guidance from survivors, including adults, children, and youth, about our programs and services. This approach ensures the meaningful involvement of survivors who use or have used our services in our planning processes, in evaluation and oversight, and in volunteer, staff, and leadership roles within our programs. Engaging in survivor-defined work also means that we are working to acknowledge and jointly confront the power imbalances in our interactions, while working to change the conditions that facilitate violence in our relationships and communities.

## Appendix B: Glossary of Terms

A note about language in this guide: terms such as “substance abuse,” “addict,” and “alcoholic” have been intentionally left out of this guide. Research shows that this kind of language is associated with lower levels of staff compassion and higher levels of stigma (Kelly & Westerhoff, 2010), both of which are barriers to healing (Moyers & Miller, 2013) and discourage seeking help (Burnette et al., 2019).

- ◇ **Abstinent, abstaining from [a specific substance], abstinence:** not using one or more substance(s).
- ◇ **Intoxicated, intoxication:** experiencing behavioral, emotional, physiological and/or cognitive changes due to recent use or exposure to a substance. Not all use results in intoxication.
- ◇ **Mutual aid:** peer-run groups where members support one another’s recovery. Examples include: 12-step, SMART Recovery, Refuge Recovery, and more.
- ◇ **Naloxone:** the medication that is used to *temporarily* reverse an opioid-related overdose.
- ◇ **Overdose:** a *relatively* large dose that has exceeded a person’s tolerance for a substance, resulting in serious (often life-threatening) negative impacts on their physical health, mental health, or both.
- ◇ **Recovery:** motivation, and/or taking steps to live a healthier, more balanced, and self-directed life.
- ◇ **Route of Administration:** method for ingesting and/or being exposed to a substance. Examples include: smoking, snorting, drinking, injecting, etc.
- ◇ **Sober, Sobriety:** clear-minded, clear-mindedness.
- ◇ **Substance:** a mind-altering drug, including alcohol. See Appendix G for more information.
- ◇ **Substance use:** the activity of using a mind-altering substance, including alcohol. Does not indicate any specific pattern of use or whether problems/risks are associated with use.
- ◇ **Substance use coercion:** the coercive tactics used against a survivor related to their history of substance use as part of a broader pattern of abuse and control by a partner/ex-partner.
- ◇ **Toxicology screening:** biomedical (urine, breath, blood, etc.) testing that detects the presence of a substance (such as urine drug testing and breathalyzers).
- ◇ **Treatment:** An array of services aimed at helping people engage in recovery from substance use, including: withdrawal management, medication assisted treatment, counseling, residential, inpatient, intensive outpatient, and/or outpatient services, and other recovery services.
- ◇ **Withdrawal:** physical, behavioral, and/or psychological changes that can occur when a person reduces or stops using a specific substance. Withdrawal can range from none to life-threatening.

## Appendix C: Myths and Misconceptions

There are many myths and misconceptions about substances and substance use, largely due to stigma. While there are many more myths than can be addressed in this guide, below are some fact-based responses to some of the most common misconceptions.

**Myth:** Supporting someone to make healthier decisions about their substance use is enabling.

**Fact:** Everyone needs access to options, support, and resources in their journey of healing.

**Myth:** Only medically trained professionals can reverse an overdose.

**Fact:** Reversing an overdose does not require medical training, this guide will outline the steps.

**Myth:** Touching fentanyl can kill you.

**Fact:** While fentanyl is a potent opioid, casual handling of fentanyl is not life-threatening.

**Myth:** People have to hit “rock bottom” before they can truly change.

**Fact:** While some people may experience a brief increase in motivation after a crisis, major losses do not make it easier for someone to engage in their recovery. Many people will die before they ever “hit bottom,” and we never want to leave someone unsupported to needlessly suffer.

**Myth:** Medication Assisted Treatment is just trading one drug for another drug.

**Fact:** FDA-approved medications do not have the same intoxicating effects as substances, and have been shown to help people become sober, engage in work and other life pursuits, and decrease negative outcomes, including incarceration, HIV, and death.

**Myth:** Naloxone (the overdose antidote) gives people permission or a “safety net” to use drugs.

**Fact:** This underestimates all the complex reasons why people use substances. Communities that have naloxone distribution programs show decreases in fatal overdoses without increases in use.

**Myth:** People who use need to go to treatment and get sober before engaging in other services.

**Fact:** The majority of individuals who use substances **do not** have a diagnoseable substance use disorder, which is a requirement for being eligible for treatment (as consistently found by SAMHSA's National Survey on Drug Use and Health). There are many pathways of recovery for those who do experience difficulties related to their substance use, and many individuals move towards their recovery goals without ever engaging in formal treatment. For those who may benefit from formal treatment, they are more likely to engage if they have empathic support from someone they trust and can access resources that increase their safety and stability.

*This area intentionally left blank.*

## Appendix D: Naloxone Instructions

Naloxone is available in three forms: intramuscular injection, nasal spray, and auto-injector. The form that someone has access to is largely based on what is available through their insurance and/or available through local naloxone distribution programs (if they are available in your community). Knowledge of how to use each form of naloxone is important in order to support someone in learning to use whichever form of naloxone they are able to access. There are many online resources that offer visual and verbal instructions, including videos.

### Nasal Spray Instructions

Open product package, insert into either nostril, and push the plunger to spray naloxone into the person's nose. Detailed written and video instructions can be found on the manufacturer's website under their "how to use" tab: <https://www.narcan.com/>.

### Intramuscular Injection Instructions

Remove orange cap from the vial, turn the vial upside down, insert the syringe. Draw back the syringe's plunger until you've drawn up 1 cc/ml of naloxone (be sure to draw up the liquid naloxone, not just air). Inject straight into a major muscle such as the shoulder (like a flu shot), the thigh, or the buttocks and push plunger down until the full dose has been given. You can inject through clothing.

### Auto-Injector Instructions

Remove the auto-injector from its product package and outer case, pull off the red safety guard, place the black end of the auto-injector against the middle outer thigh (through clothing is fine), push down until you hear a click and hiss, and continue to press down for five seconds. This product has a voice recording that will count down five seconds, but if for some reason the voice recording is not working, the product will still work to deliver the dose of naloxone. Detailed written and video instructions can be found on the manufacturer's website: <https://www.evzio.com/patient/how-to-use-evzio/>.



## Additional Resources on Using Naloxone

Here is an additional resource for written instructions: <https://www.getnaloxonenow.org/INFO-ON-HOW-TO-ADMINISTER-NALOXONE.pdf>

There are many videos created by different harm reduction groups, public health administrations, and other health providers that include information on recognizing overdose and reversing it using naloxone. Here is a link to a video by the Chicago Recovery Alliance, available in English and in Spanish: <https://anypositivechange.org/preventing-empty-spaces/>

Overdose situations can be frightening and it is empowering to know what can be done to save someone's life!

*This area intentionally left blank.*

## Appendix E: Safer Bathrooms

Here's a selection of practices that can help make bathrooms safer for survivors and staff, many of which were selected from the policies and procedures put forth by the New York State Department of Health AIDS Institute (2016).

- Have well-lit restrooms.
- Have a sharps disposal container posted in bathrooms.
- Have a means of accessing the bathroom if it is locked and the person inside has become unresponsive. Some programs have installed keyless entry systems, or have installed keyed locks and have a spare key for emergency access.
- Have the restroom entry door swing outward (rather than inward) so that door can be more easily opened if the person inside has lost consciousness and is laying in front of the door (if it swings inward, it may be difficult to open quickly if the person is unconscious and blocking the door).
- Respect every person's dignity and privacy, and also politely check on them if you notice they have been in the restroom a long time.
- If possible, an area separate from toilet facilities should be made available for people who may need to inject medication (such as insulin). This area should offer counter/table space so individuals don't need to place items on floor, and a chair, to prevent individuals from falling, all of which should be made of non-porous materials that can be easily cleaned.

## Appendix F: Mutual Aid Resources

Mutual aid recovery resources play an important role for many individuals, though not all. Historically, 12-Step programs have not typically been responsive to the realities of minorities, women, and individuals with mental health and/or trauma histories. That said, 12-Step programs have come a long way in attempting to be more inclusive and ultimately, the individual is the only one who knows what will and won't work for them. For that reason, it is best practice to provide information on an array of different kinds of mutual aid resources, and help the individual to explore what they may find helpful, as well as help them to anticipate and plan for any safety needs that may be raised by accessing this form of support. Here's an array of different mutual aid recovery resources:

- HAMS: Harm Reduction for Alcohol: [www.hamsnetwork.org](http://www.hamsnetwork.org)
- Women for Sobriety: [www.womenforsobriety.org](http://www.womenforsobriety.org)
- Recovery Dharma: <https://recoverydharma.org>
- Smart Recovery: <http://www.smartrecoverychicago.org>

### 12-Step Based

- A Woman's Way through the Twelve Steps: [www.stephaniecovington.com/a-womans-way-through-the-twelve-steps.php](http://www.stephaniecovington.com/a-womans-way-through-the-twelve-steps.php)
- Alcoholics Anonymous: <http://www.aa.org>
- Dual Recovery Anonymous: <http://www.draonline.org>
- Narcotics Anonymous: <http://www.na.org>

For more information on mutual aid approaches as well as Recovery Community Organizations, see Faces and Voices of Recovery: <https://facesandvoicesofrecovery.org>

## Appendix G: Information on Commonly Used Substances

The most commonly used substances in the U.S. are alcohol and cannabis (SAMHSA NSDUH, 2019). That said, many people may also have histories of using methamphetamine, cocaine, opioids (including heroin as well as prescription medications), and other prescription medications (such as medications used in the treatment of anxiety or insomnia) that may pose risks when not used as prescribed. Here are two resources that can be useful in learning more about different substances, their effects, and potential risks:

- National Institute on Drug Abuse: <https://www.drugabuse.gov/drugs-abuse>
- KFx Learning of Substance: [http://kfx.org.uk/drug\\_facts.php](http://kfx.org.uk/drug_facts.php)

For information on better vein care and safer injection practices, please see:

- Chicago Recovery Alliance's Better Vein Care: <http://anypositivechange.org/better-vein-care/>
- Harm Reduction Coalition's Getting Off Right Safety Manual: <https://harmreduction.org/drugs-and-drug-users/drug-tools/getting-off-right/>